SUICIDE PREVENTION SUMMIT

SUICIDE PREVENTION SUMMIT

Raising awareness and hope in the community

Welcome

Increase your understanding of suicide, its prevalence and the risk factors for specific populations, and acquire tools for prevention, assessment and intervention.

Awareness Event |Tuesday, Sept. 20 | 6-7:30 pm

Location: Riverside Park | La Crosse, Wis.

Summit | Wednesday, Sept.21 | 8:30 am-4:30 pm

Location: La Crosse Center | South Hall | 300 Harborview Plaza | La Crosse, Wis.

Welcome | Committee

Welcome | Committee

2016 Suicide Prevention Summit Planning Committee Members

Nikki Balsamo, Viterbo University
Barbara Blank, Care Center
Tim Blumentritt, B.S.W., Care Center
Henry Greengrass, Ho Chuck Nation Youth Services
Vicky Gunderson, Community Participant and Parent Advocate
Jeannie Hanley, Ed.D., Winona State University Adjunct Faculty
Christine Hughes, M.S.W., Mayo Clinic Health System Behavioral Heath
Amy Kuester, CIRS, Great Rivers 211
Deb Mahr, Kaitlin's Table
Geri Mulliner, R.N., Gundersen Health System Behavioral Health
Matthew R. Poje, M.A., L.P.C., Logistics Health Inc.
Jenny Root, B.S., La Crosse County Human Services
Judy Shoults, Community Member, Mental Health Coalition Board
Alicia Skiles, Family and Children Center
Deb Stelmach, Driftless Recovery Services
Maria Towle, Western Wisconsin Cares
Melissa Webster, UW-La Crosse Continuing Education/Extension

Who should attend:

- Psychologists
- Social workers and counselors
- Teachers
- School guidance counselors
- Clergy and pastoral care
- Law enforcement officials
- Nurses
- Paramedics
- Medical assistants
- Youth leaders
- Student service personnel
- Interested/affected community members

In partnership:

La Crosse Area Suicide Prevention Initiative

UW-La Crosse Continuing Education/Extension

2016 Suicide Prevention Summit sponsors:

MAYO CLINIC HEALTH SYSTEM

La Crosse County Human Services

Connecting the university and the community!

608.785.6500

866.895.9233

conted@uwlax.edu

UWL Continuing Education
205 Morris Hall
1725 State Street
La Crosse, WI 54601, USA

Offering programs and services to meet the diverse needs of individuals of all ages!

SUICIDE PREVENTION SUMMIT

CALL FOR PROPOSALS

Raising awareness and hope in the community

Call for proposals

September 2017

- Proposal deadline: **TBD**
- Notification emails will be sent on or before: **TBD**

Submit your program proposal now for consideration. Programs applicable to all aspects of suicide prevention are welcome.

Suggested topics:

- Building Resiliency
- Cultural considerations with suicide
- Developmental considerations with suicidal idealization from childhood to late in life
- Managing chronic suicidal idealization
- Men and suicide
- Spiritual considerations with suicide
- Stigma and suicide
- Suicide in children

Suicide in the college age population

- Suicide in the Serious Persistent Mentally Ill population
- Veterans and suicide

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REGISTER

Raising awareness and hope in the community

Register

Cost:

Fees include refreshments and lunch.

- **$90,** early bird, on/before August 26
- **$120,** attendee fee
- **$50,** student (must present student ID at registration)
- **$15**, APA or NBCC Continuing Education (CE) hours

Register online

Scholarship

If you are interested in a scholarship, please email a 300 word explanation of why you are requesting the scholarship and your contact information to conted@uwlax.edu by **September 1**. We will notify you two weeks prior to the Summit regarding your scholarship eligibility.

Cancellation policy

Substitutions welcome. Full refund less $25 processing fee two weeks prior to event, no refunds thereafter. Cancellations must be submitted in writing to: conted@uwlax.edu.

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2016 SUICIDE PREVENTION SUMMIT

RAISING AWARENESS AND HOPE IN THE COMMUNITY

WEDNESDAY, SEPT. 21
8:30 A.M.-4:30 P.M.
LA CROSSE CENTER

In partnership with:

La Crosse Area Suicide Prevention Initiative

UW-La Crosse Continuing Education/Extension

www.uwlax.edu/conted/sps

2016 SUICIDE PREVENTION SUMMIT

WELCOME

Welcome to the 2016 Suicide Prevention Summit and to the Coulee Region. We hope that the Summit is helpful, hopeful and empowering. Your participation strengthens all of us and makes our communities better. Here are a few details to assist you:

Exhibit & Information Tables are open throughout the conference. Our sponsors have resources for you to take and share with others. Thanks to all!

- 7 Rivers LGBTQ Connection
- Family & Children's Center
- Great Rivers 211
- Gundersen Medical Foundation & Kaitlin's Table
- Joe Was Just Joe Foundation
- La Crosse County Human Services & Aging and Disability Resource Center
- Logistics Health, Inc.
- Marian University
- Mayo Clinic Health System
- National Alliance on Mental Illness (NAMI) La Crosse County
- Tomah VAMC
- University of Wisconsin-La Crosse Active Minds
- University of Wisconsin-La Crosse Sigma Tau Gamma
- Veterans Health Administration
- Western Wisconsin Cares

The Summit Bookstore is provided by Western Technical College Campus Shop. Thank you to Manager, Dave Wigness, for making this possible.

Lunch is served in the lower level of the South Hall and begins at noon.

Evaluations help the Suicide Prevention Summit Planning Committee Initiative develop next year's event. Please look for the evaluation in your email inbox shortly after the Summit.

Certificates of Completion will be sent via email approximately two weeks after the Summit. APA and NBCC seeking CE hours must sign in and out.

Questions are directed to conference staff and the La Crosse Area Suicide Prevention Initiative. Staff members are wearing red board member ribbons on their name badges.

2016 SUICIDE PREVENTION SUMMIT SCHEDULE

7:30-8:30 a.m.	**Registration & Continental Breakfast**	Upper Foyer
8:30-9 a.m.	**Welcome**	Ballroom A/B

9-10:15 a.m. **KEYNOTE SESSION:** Ballroom A/B

Self-Injury and Suicide: Update on Best Practices for Conceptualizing and Responding to Risk

Jennifer Muehlenkamp, Ph.D.

Non-suicidal self-injury (NSSI) poses a challenge to many clinicians, and family members, who frequently worry about the potential for the individual to become suicidal. It is well established that NSSI is not a guarantee of suicide risk, but does increase risk for suicide. Being able to effectively monitor suicide risk among those who are self-injuring is critical. Using examples of lived experience, this presentation will highlight current knowledge of features of self-injury that appear to be linked to future suicide risk and also provide strategies of how best to respond to NSSI when suicide risk is of concern. Strategies for assessing, monitoring, and responding to suicide risk will be discussed with particular attention being paid to how strategies are perceived by the individual to ensure maximum success. By incorporating research and lived experience, this presentation will provide an essential update regarding the complex relationship between self-injury and suicide.

Learning Objectives:

1. Participants will be able to identify features of NSSI associated with increased risk for suicide
2. Participants will be able to describe effective strategies for eliciting information needed to evaluate suicide risk
3. Participants will able to apply a framework for conceptualizing suicide risk that can foster rapport and convey support

10 a.m.-4:30 p.m.	**Bookstore/Exhibitors**	Ballroom Hallway
10:15-10:30 a.m.	**Break**	Ballroom Hallway

10:30-11:45 a.m. **CONCURRENT SESSIONS:**

De-Escalation of Children in Crisis

Ballroom A/B

Joel Rooney, Psy.D. & Michelle Rooney, B.A. Social Work

De-escalation with children and adolescents in crisis is a very dynamic process involving not only the complexities and uniquenesses of the individual children in crisis, but quite often other family members and their relationship to the child. What is less known is the importance of self-regulation of those attempting to help "co-regulate" a crisis situation. This brief presentation will address the issues of de-escalation of children and families by using principles of self regulation and effective communication - with a particular reference to life disruptions involving trauma and affecting attachment. Such discussions will be paralleled with video examples and case discussions.

Learning Objectives:

1. Attendees will gain an understanding of important principles involving effective self-regulation during a crisis.
2. Attendees will gain an understanding of important principles surrounding effective communication with others during a crisis.
3. Attendees will be exposed to examples of the above principles applied in the form of video examples and clinical case discussions from the presenters.

Suicide Prevention and the Transgender Community

Boardroom A

Jackson Jantzen

During this session we will discuss what it means to identify as a transgender individual and address barriers the members of this community face. We'll address the risks, warning signs, prevention and resources available, as well as statistics related to suicide and it's impacts on this community.

Learning Objectives:

1. The group will have a clear understanding as to what being Transgender means and unique concerns this community faces.
2. Risk: Present statistical information on how suicide impacts the transgender community.
3. Prevention - Understanding resources available for the trans community and professionals.

This session does not qualify for APA or NBCC.

SESSIONS CONTINUED ON NEXT PAGE

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What hurts ... Working in the Aftermath of Suicide

South Hall Lower B1

Barb Smith, Certified trainer, Expert in suicide prevention, intervention and aftercare of suicide

Working with people bereaved by suicide can be challenging and uncomfortable but doesn't always have to be complicated. Case stories will be shared from speakers 25 years in the professional field of suicide and her lived experiences. Understanding "why suicide" is important when those survived by suicide are searching for answers. Something as small as HOPE and being heard can make a difference in a person's grief journey and can decrease chances of another potential loss to suicide. Best practices and suicide statistics will be shared to understand the likelihood of being in the presence of suicide grief and being effective in helping to support a new life.

Learning Objectives:

1. Participants will learn simple yet effective tools that help in working with the those bereaved by suicide
2. Understanding why people die by suicide will increase the knowledge of participants so they can better support those bereaved by suicide
3. Addressing challenges those bereaved by suicide might experience when supporting them in both clinical and non clinical setting

This session does not qualify for APA or NBCC.

HOPELINE – Help is Just a Text Away

South Hall Lower B2

Barb Bigalke, CISM

Learn about HOPELINE – the statewide text based support. The HOPELINE is a text based emotional support line that is a resource for the State of Wisconsin. Come learn about the resource, how to use it, and ways you can utilize the resource. And learn about what trends that are being seen and how and what is working to help in these situations. Data about what our top topics The HOPELINE is a text based emotional support line that is a resource for the State of Wisconsin. Come learn about the resource, how to use it, see a live demo of the HOPELINE. As learn about what trends that are being seen and how and what is working to help in these situations.

Learning Objectives:

1. Learn about the HOPELINE
2. How Can the Data Help Know what is Happening in our State
3. Ways to Utilize the HOPELINE

This session does not qualify for APA.

12-1 p.m. **LUNCH** South Hall Lower B3/B4

1-1:30 p.m. **Self Care: Making #1 #1** Ballroom A/B

Sarah Johnson, M.S, LPC

Passionate, caring people often forget to put ourselves first. This brief, interactive workshop will remind us of the importance of making #1 (ourselves) a #1 priority in order to be healthier and more effective in our lives.

Learning Objectives:

1. Identify the importance of self care.
2. Learn and practice a self care strategy.
3. Identify a strategy participants can commit to in order to enhance their self care and health.

1:45-3 p.m. **CONCURRENT SESSIONS:**

Suicide Risk Formulation: New Models for Best Practice

South Hall Lower B1

Jennifer Muehlenkamp, Ph.D.

This session will provide an update on current evidence-based models being used for evaluating suicide risk. Recommended features to consider in your risk assessment will be reviewed as well as strategies to elicit the information. Best practice assessment and conceptualizations of suicide risk will be integrated into the presentation along with some interactive case examples. Clinicians will leave with a new, user-friendly way to better understand and monitor suicide risk in their clients.

Learning Objectives:

1. Participants will be able to describe the fluid suicide risk formulation model
2. Participants will be able to apply the risk formulation model to current clients
3. Participants will be able to identify intervention strategies based on the risk formulation model

Update on Depression, Suicide, and Gender

Ballroom A/B

David Mays, M.D., Ph.D.

Depression is one of the top five risk factors for suicide death. Over the last five years our understanding of the biology of depression has been challenged by new physiologic models that reflect brain networks rather than brain chemistry. In addition, genetic information has provided new insights into gender differences in the epidemiology and presentation of depression. This breakout session will explore these most recent ideas with the goal of reducing suicide risk.

Learning Objectives:

1. Be able to recognize the difference between the neurotransmitter versus the brain circuit model of depression
2. Understand the genetic findings relating to the gender expression of depression
3. Have insight into ways of investigating depression in suicide in men and women

The Role of Resilience in Suicide Prevention: Working with College Students and other Emerging Adults

Boardroom B

Gretchen Reinders, Ph.D., LP

In the past decade there has been growing attention paid to the millennial generation's increasing mental health problems. Phrases such as "College of the Overwhelmed" and "Generation Stress" permeate the media and influence these emerging adults, as well as those with whom they work and interact. This program will discuss both the merits and problems associated with the common public perception that today's college students and emerging adults are incapable of tolerating distress or functioning on their own. It will provide a more accurate depiction of mental health concerns, suicidality, and resilience in this population. This program will also introduce the work being done around resilience, and will engage participants in generating ideas for cultivating resilience, especially as it relates to suicide prevention.

Learning Objectives:

1. Learn about trends specific to college student and emerging adult mental health.
2. Review of clinical assessment measures and treatment interventions specific to resilience.
3. Identify strategies for building resilience and learn how to apply these strategies for suicide prevention work with college students and emerging adults.

SESSIONS CONTINUED ON NEXT PAGE

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QPR - Question, Persuade, Refer

Boardroom A

Christine Hughes, MSW, LCSW

Three simple steps that anyone can learn to help save a life from suicide. Just as people trained in CPR and the Heimlich Maneuver help save thousands of lives each year, people trained in QPR learn how to recognize the warning signs of a suicide crisis and how to question, persuade, and refer someone to help.

Learning Objectives:

1. Identify warning signs that someone might be considering suicide.
2. Learn to offer hope and how to ask if someone is thinking about suicide
3. How to make a referral for person to get help

Connecting Childhood Trauma with Mental Illness & Suicide through Interactive Discussion and Questioning

South Hall Lower B2

Tom Trannel, M.D.

This session will be largely interactive, exploring current practice strategies, available research, and sharing audience experiences.

Learning Objectives:

1. Explore theoretical connections and available research about children who have experienced trauma and possible associated suicidality.
2. Discuss practice strategies for working with children with trauma and associated suicidality through audience discussion and questioning
3. Compare and critique current practices of working with children with trauma and assessing child suicidality through audience discussion and questioning

This session does not qualify for APA or NBCC.

3-3:15 p.m.	**Break**	Ballroom Hallway

3:15-4:30 p.m. **KEYNOTE SESSION:** Ballroom A/B

The Secret of Happiness

David Mays, M.D., Ph.D.

Happiness is not the absence of misery. It is a unique mind state that is universally sought after, and consistently misunderstood. Take heart. This keynote will explain what scientists know about happiness, and everything you need to know about making yourself and your clients happier. Your happiness is there for the taking, if you can avoid the common traps and misconceptions.

Learning Objectives:

1. Recognize the common traps that people make when they try to make themselves happy
2. Understand how modern psychology conceptualizes happiness
3. Learn some key behaviors that can lead to greater happiness in yourself and others

4:30 p.m.	**Adjourn**

2016 SUICIDE PREVENTION SUMMIT SPEAKERS

Barb Bigalke founded and is the executive director of The Center for Suicide Awareness, a 501c3 nonprofit, located in Kaukauna, WI. She is certified in the Mitchell Model for Suicide Prevention, Intervention, Postvention, De-Briefing and Group and Individual Crisis Intervention. She is a certified CIT officer and is part of the Manitowoc County CISM team. She is certified by the National Organization for Victim Assistance (NOVA) in Crisis Response Team Training. She is a certified QPR instructor. She is certified by the Wisconsin Brain Institute in Brain spotting and EMDR. She holds certifications in Trauma Informed Care and Collaborative Assessment and Management of Suicidality. She is part of the Special Task Force in Madison for Victim Rights. She is a certified facilitator by the AFSP. She chairs the Fox Valley Grief Network and the Calumet County Prevent Suicide Coalition. Barb holds degrees in Psychology, Human Development and Mental Health Counseling. Bigalke founded the Walk for Suicide Awareness and the Ride for Suicide Awareness. She has been an adjunct teacher for Fox Valley Technical College for the past 16 years. Bigalke has brought the first Text Based Support called HOPELINE to our state.

Christine Hughes has been an therapist at Mayo Clinic for 12 years, an active member of the La Crosse Area Suicide Prevention Initiative, Inc. since 2007 and certified Gatekeeper instructor from the QPR Institute to train lay people on warning signs of depression and suicidality. She has experience working with children and adults dealing with depression and anxiety. Hughes is a certified Wellness Coach to promote healthy behaviors that promote overall wellness.

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David Mays, M.D., Ph.D., is a licensed physician in the state of Wisconsin. He is Board Certified by the American Board of Psychiatry and Neurology, and has Additional Qualifications in Forensic Psychiatry. He has a dual appointment as a clinical adjunct assistant professor in the University of Wis. Dept. of Psychiatry and Department of Professional Development and Applied Studies. He is a Life Fellow of the American Psychiatric Association, member of the Wisconsin Psychiatric Association, and a member of the American Academy of Psychiatry and the Law. Over the last 23 years, Mays has practiced psychiatry in a variety of settings, including an HMO, an assertive community treatment program, private clinical and forensic practice, and as the clinical director of the forensic program at the Mendota Mental Health Institute. This forensic program is a 180-bed program with the only maximum security forensic unit in the state of Wisconsin. Mays was the treating psychiatrist on the most restrictive unit in maximum security, housing some of the most dangerous psychiatric patients in the state.

Mays has received numerous awards for his teaching and clinical work, including the Distinguished Service Award from the Alliance on Mental Illness in Dane County, the Exemplary Psychiatrist Award from the National Alliance on Mental Illness, the Exceptional Performance Award from the Wisconsin Health and Family Services, the 2006 Outstanding Professional Award from the Wisconsin Association on Alcohol and Other Drug Abuse, and the 2010 Outstanding Mental Health Professional Award from the Wisconsin National Alliance on Mental Illness. He is a highly sought after presenter on numerous topics in mental health, including psychiatric diagnosis and treatment, personality disorders, suicide and aggression risk management, mainstream and alternative treatments in psychiatry, and the biology of ethics.

Jennifer J. Muehlenkamp, Ph.D., is a licensed clinical psychologist and associate professor of psychology at the University of Wisconsin-Eau Claire. She currently directs the UWEC Suicide Prevention and Research Collaborative in addition to her teaching, service, advising, and research responsibilities. Muehlenkamp is a recognized expert in the field of suiciodology and suicide prevention, having published over 90 empirical papers and book chapters focused on self-injury and suicide risk, assessment, and treatment. Her work has earned awards from the American Association of Suicidology (AAS) and the Self-Injury Awareness Network, Inc., as well as has been featured in major media outlets such as the Wall Street Journal and the American Psychological Association's monthly newsletter, The Monitor. She currently is President of the International Society for the Study of Self-Injury and a steering committee member of Prevent Suicide Wisconsin.

Gretchen Reinders, Ph.D., is a licensed psychologist and Director of the Counseling & Testing Center (CTC) at UW-La Crosse. She earned her B.A. from UW-Madison in 1999, M.Ed from University of Missouri-Columbia in 2002, and Ph.D. in Counseling Psychology from the University of Missouri-Columbia in 2006. She has over 10 years of experience in university counseling settings.

Joel Rooney, Ph.D., is a licensed psychologist who practices at La Crosse County Human Services, whilst also providing consultative services for the surrounding community. He has advanced training in trauma informed care, attachment informed care, as well as motivational interviewing. In addition to the assessment and individual therapeutic roles he serves through La Crosse County, he has also served as the clinical director for the La Crosse County Crisis Program for nearly 12 years. Prior to his professional roles in the La Crosse area, Rooney served as the 82nd Airborne's Division Psychologist for a four year duration, which included a one year tour of duty in Baghdad, Iraq - with the primary missions of both post traumatic stress and suicide prevention.

Michelle Rooney is a child protective services ongoing unit social worker with over 22 years of experience working with Children and Families. She is a frequent presenter to our community's CASA volunteers, and was part of a task force to help develop a manual to support domestic violence prevention for Wisconsin's counties. She has a passion to ensure that families within her care possess environments that allow children to develop safely and effectively, and have the resources to do so.

Barb Smith is a trained prevention, intervention and aftercare specialist in the field of suicide. Smith is dedicated to this field for the past 26 years. As a professional trainer she has presented to over 60,000 people including youth, medical field, faith community, first responders and those who work with the bereaved. As a survivor to her brother and sister laws suicide Smith's expertise is both from a professional and lived experience view. She is a master trainer of ASIST (applied suicide intervention skills training), registered safeTALK trainer (suicide alert for everyone) T4T Yellow Ribbon youth suicide awareness program, founder and facilitator for Survivors of Suicide Support group, Victims advocate for our sheriff dept., outreach coordinator for those who are newly bereaved by suicide and an author of her personal story published in *'iMpossible Project* book. Smith is the go to person in her community and around the state for resources and expertise in prevention, intervention and the aftercare of suicide.

Tom Trannel, Ph.D., a child psychiatrist and practicing clinician, will facilitate a review and discussion of working with children with trauma and the connection with mental illness and suicidality.

La Crosse Area Suicide Prevention Initiative

THANK YOU TO OUR SPONSORS

Kaitlin's Table Fund

GUNDERSEN MEDICAL FOUNDATION

LHI LOGISTICS HEALTH INCORPORATED

La Crosse County Human Services

joewasjustjoe. foundation

MAYO CLINIC HEALTH SYSTEM

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AWARENESS EVENT

Raising awareness and hope in the community

Awareness event

Awareness Event |Tuesday, Sept. 20 | 6-7:30 pm

Location: Riverside Park | La Crosse, Wis. (featuring music and speakers)

For more information: www.lacrossesuicideprevention.org

Email: info@lacrossesuicideprevention.org

Call: 211 or 1.800.362.8255

Free and open to the public

Speakers rain or shine. Music weather permitting.

SUICIDE PREVENTION SUMMIT

KEYNOTE PRESENTERS

Raising awareness and hope in the community

Keynote presenters

David Mays | Jennifer Muehlenkamp

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CONCURRENT PRESENTERS

Raising awareness and hope in the community

Concurrent presenters

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safely and effectively, and have the resources to do so.

Barb Smith

Barb Smith is a trained prevention, intervention and aftercare specialist in the field of suicide. Barb is dedicated to this field for the past 26 years. As a professional trainer she has presented to over 60,000 people including youth, medical field, faith community, first responders and those who work with the bereaved. As a survivor to her brother and sister laws suicide Barb's expertise is both from a professional and lived experience view. She is a master trainer of ASIST (applied suicide intervention skills training), registered safeTALK trainer (suicide alert for everyone) T4T Yellow Ribbon youth suicide awareness program, founder and facilitator for Survivors of Suicide Support group, Victims advocate for our sheriff dept., outreach coordinator for those who are newly bereaved by suicide and an author of her personal story published in *'iMpossible Project book*. Barb is the go to person in her community and around the state for resources and expertise in prevention, intervention and the aftercare of suicide.

Dr. Tom Trannel

Dr. Trannel, a child psychiatrist and practicing clinician, will facilitate a review and discussion of working with children with trauma and the connection with mental illness and suicidality.

SUICIDE PREVENTION SUMMIT

CEUS/CE HOURS

Raising awareness and hope in the community

CEUs/CE hours

Continuing Education Units (CEUs) are a means of recognizing and recording satisfactory participation in non-degree programs. University of Wisconsin-Extension (UW-Ex) awards one CEU for each 10 contact hours in a continuing education experience. Actual contact hours are recorded. CEUs are offered at no additional charge, through the UW-Ex. In order to receive a certificate, participants need to sign up for CEUs at the time of registration. (.55 CEUs/5.5 contact hours)

- UW-Ex CEUs fulfill continuing education requirements for many professionals, agencies and organizations. Professional associations may have specific licensing requirements. Individuals should contact their licensing association before assuming UW-Ex CEUs will fulfill all requirements.
- UW-La Crosse keeps records of individual CEUs for three years of programming. Certificates are emailed within two weeks of the conclusion of each program. Requests for duplicate CEU certificates are charged a $15 processing fee. Request form for duplicate CEU hours & certificates

National Board for Certified Counselors (NBCC)

University of Wisconsin-La Crosse (UWL) has been approved by NBCC as an Approved Continuing Education Provider, ACEP No. 6303. Programs that do not qualify for NBCC credit are clearly identified. UW-L is solely responsible for all aspects of the programs. (5.5 CE hours)

- Additional $15 fee for NBCC hours.

Continuing education for psychologists:

University of Wisconsin-La Crosse (UWL) is approved by the American Psychological Association (APA) to sponsor continuing education for psychologists. UW-L Continuing Education and Extension maintains responsibility for the program and its content. (5.5 CE hours)

- Additional $15 fee for APA hours.

CE units/hours: *UW-L is authorized to offer APA, NBCC and UWL Continuing Education units. It is the responsibility of the attendee to make sure these are acceptable with their institution, agency or affiliation. Certificates will be emailed after the conclusion of the conference.*

Connecting the university and the community!

608.785.6500

866.895.9233

conted@uwlax.edu

UWL Continuing Education
205 Morris Hall
1725 State Street
La Crosse, WI 54601, USA

Offering programs and services to meet the diverse needs of individuals of all ages!

SUICIDE PREVENTION SUMMIT

UNIVERSITY UG/GRAD CREDIT

Raising awareness and hope in the community

University UG/GRAD credit

Suicide Prevention Summit Independent Study

September 21-October 21, 2016 ***(15 hours as arranged)***

UW-La Crosse offers 1 UG/GRAD credit

University UG/GRAD credit is available to Suicide Summit participants. The student must attend the summit to receive credit. Registration and payment can be made at the summit or by contacting Briana Meuer at bmeuer@uwlax.edu or 608.785.6513.

HED 495/595, section 700
Deadline: September 21, 2016
UW-La Crosse online admission application, credit course registration form and payment must all be received by deadline.

This course is designed for participants attending the Suicide Prevention Summit on September, 21, 2016. In addition to attending workshops on updated information pertaining to suicide, this course will allow participants to explore how his/her current workplace can collaborate to best support the mental and emotional health of

students/clients/patients.

Summit registration is separate and in addition to university credit course registration.

UWL academic credit registration form and online admission application directions PDF

To register, please contact:

Briana Meuer, Credit Coordinator
608.785.6513 or toll free 1.866.895.9233
bmeuer@uwlax.edu

Connecting the university and the community!

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866.895.9233

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UWL Continuing Education
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SUICIDE PREVENTION SUMMIT

SPONSORSHIP & EXHIBITOR INFORMATION

Raising awareness and hope in the community

Sponsorship & exhibitor information

Sponsors/exhibitors register online

Sponsorship space cost:

Summit sponsorships offer marketing opportunities that provide increased visibility to attendees. Consider the following levels of sponsorship to match your goals and budget:

$2,000+ - Gold Sponsorship

- Brief description of your organization in conference folder
- Mention on the Suicide Summit homepage
- One registration that includes lunch and refreshment breaks
- Up to two, 6-foot tables for exhibit space
- Sponsor one AM or PM break with organization name on signage at break tables

$1,000 - Silver Sponsorship

- Brief description of your organization in conference folder
- Mention on the Suicide Summit homepage
- One registration that includes lunch and refreshment breaks
- Up to two, 6-foot tables for exhibit space

Exhibitor space cost*:

$100 - Exhibitor

- One registration that includes lunch and refreshment breaks
- One, 6-foot table for exhibit space

***Exhibitor times:** Wednesday, Sept. 21, 7 am-5 pm (includes setup/teardown time). Electricity hook-up NOT guaranteed.*

Cancellation policy:

Substitutions welcome. Full refund less $25 processing fee two weeks prior to event, no refunds thereafter. Cancellations must be submitted in writing to: conted@uwlax.edu.

Registration implies permission for photos, publicity and inclusion in a participant list, unless Continuing Education/Extension is notified in writing prior to the program: conted@uwlax.edu.

Connecting the university and the community!

SUICIDE PREVENTION SUMMIT

HANDOUTS

Raising awareness and hope in the community

Handouts

David Mays, M.D., Ph.D. handouts:

- Happiness presentation PDF
- Happiness bibliography PDF
- Major Mental Illness bibliography PDF
- Men and Depression presentation PDF
- Suicide bibliography PDF

Great Rivers 2-1-1 Directory PDF

De-Escalation of Children in Crisis PDF - Joel Rooney, Psy.D. & Michelle Rooney

What hurts...Working in the Aftermath of Suicide PDF and Recommended books PDF - Barb Smith

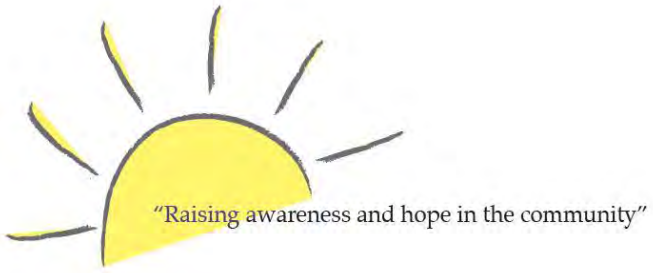
Suicide Risk Formation PDF - Jennifer Muehlenkamp, Ph.D.

The Role of Resilience in Suicide Prevention: Working with College Students and other Emerging Adults PDF - Gretchen Reinders, Ph.D., LP

QPR Gatekeeper Training PDF - Christine Hughes, MSW, LCSW

La Crosse Area

Suicide Prevention Initiative



Directory of Mental Health Resources for Suicide Prevention

June 2016

Great Rivers 2-1-1™
Get Connected. Get Answers.

The La Crosse Area Suicide Prevention Initiative and Great Rivers 2-1-1 compiled this guide to help people who are struggling with suicide issues in the La Crosse area.

Table of Contents

Information in this guide is provided by Great Rivers 2-1-1. La Crosse County information is included. For information on resources in other counties **contact** *Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 (or visit the Web site at www.greatrivers211.org).*

MENTAL HEALTH RESOURCES

24-HOUR MENTAL HEALTH CRISIS INTERVENTION RESOURCES

Great Rivers 2-1-1

24-hour 3-Digit Crisis Line 2-1-1

24-hour Toll Free Crisis Line ..... (800) 362-8255

Internet Web Site: www.greatrivers211.org

Area Served includes: Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin; Fillmore, Houston, and Winona Counties in Minnesota; Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa

La Crosse County Human Services Department ..... (608) 784-4357 (784-HELP)

Area Served includes: La Crosse County

Note: *Mental health crisis intervention services for La Crosse county; call Great Rivers 2-1-1 for information about other counties*

SUICIDE HOTLINES

Great Rivers 2-1-1

24-hour 3-Digit Crisis Line 2-1-1

24-hour Toll Free Crisis Line ..... (800) 362-8255

Internet Web Site: www.greatrivers211.org

Area Served includes: Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin; Fillmore, Houston, and Winona Counties in Minnesota; Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa

Boys Town National Hotline ..... (800) 448-3000

Internet Web Site: www.boystown.org

- *Provides a short-term crisis hotline for children and families experiencing difficulties*

Alternate Web Site for Teens: www.yourlifeyourvoice.org **HELP VIA ONLINE CHAT AND TEXTING IS AVAILABLE ON THIS WEB SITE**

TEXT (available form 4 pm – 1 am daily).....20121

Area Served: Nationwide

HOPELINE – Texting Crisis Line 741741

Area Served includes: All of Wisconsin

Note: *Texting line only; no phone calls*

Kristin Brooks Hope Center – National Hopeline Network ..... (800) 442-4673

Internet Web Site: www.hopeline.com

- *Provides telephone crisis counseling and suicide intervention*

Area Served: Nationwide

National Suicide Prevention Lifeline..... (800) 273-8255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides a suicide prevention service available to individuals in emotional crisis who are seeking help*

Area Served: Nationwide

The Trevor Project Lifeline ..... (866) 488-7386

Internet Web Site: www.thetrevorproject.org **HELP VIA ONLINE CHAT ON THIS WEB SITE**

Texting Available 3 pm – 7 pm Thursday and Friday.....Text the word Trevor to 1-202-304-1200

- *Suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth*

Area Served: Nationwide

You Matter..... (800) 273-8255

Internet Web Site: www.youmatter.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides help and support for teenagers, college students, and young adults*

Area Served: Nationwide

Your Life Iowa – Youth Suicide Prevention Line..... (855) 581-8111

Internet Web Site: www.yourlifeiowa.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

Texting Available 2 pm – 10 pm Daily..... (855) 895-8398

- *Provides telephone crisis counseling and suicide intervention for youth*

Area Served: Iowa

Veterans Crisis Line.....(800) 273-8255 then press 1,.... or send a text message to 838255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides suicide prevention services to veterans in emotional crisis*

Area Served: Nationwide

SUICIDE-RELATED WEBSITES

American Association of Suicidology	www.suicidology.org
American Foundation of Suicide Prevention	afsp.org
JED Foundation (suicide prevention among college students)	www.jedfoundation.org
Mental Health America of Wisconsin	www.mhawisconsin.org

National Hopeline Network	www.hopeline.com
Prevent Suicide Wisconsin	www.preventsuicidewi.org
Suicide Awareness and Voices of Education	www.save.org
Suicide Prevention Resource Center	www.sprc.org
Wisconsin Department of Public Instruction	http://sspw.dpi.wi.gov/sspw_suicideprev
Wisconsin Injury Prevention Program	http://www.dhs.wisconsin.gov/health/injuryprevention/index.htm

SUICIDE RESOURCES FOR SPECIAL POPULATIONS

(Serves Nationwide unless noted)

YOUTH

Boys Town National Hotline..... (800) 448-3000

Internet Web Site: www.boystown.org

- *Provides a short-term crisis hotline for children and families experiencing difficulties*

Alternate Web Site for Teens: www.yourlifeyourvoice.org HELP VIA ONLINE CHAT AND TEXTING IS AVAILABLE ON THIS WEB SITE

Text VOICE to 20121

National Graduate Student Crisis Line..... (877) 472-3457

Internet Web Site: www.gradresources.org/crisisline

- *Provides immediate help for graduate students in crisis*

The Trevor Project Lifeline ..... (866) 488-7386

Internet Web Site: www.thetrevorproject.org **HELP VIA ONLINE CHAT ON THIS WEB SITE**

Texting Available 3 pm – 7 pm Thursday and Friday.....Text the word Trevor to 1-202-304-1200

- *Suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth*

You Matter..... (800) 273-8255

Internet Web Site: www.youmatter.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides help and support for teenagers, college students, and young adults*

Youth America Hotline..... (877) 968-8454

Internet Web Site: http://www.yourlifecounts.org/

- *Provides a teen-to-teen peer counseling hotline*

VETERANS

River Valley Integrated Health Center – Mental Health Clinic..... (800) 827-8662, ext. 63301

- *Outpatient mental health services*

Area Served: Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa; Fillmore, Houston, and Winona Counties in Minnesota; Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin

Veterans Affairs Medical Center – Tomah..... (800) 872-8662

Internet Web Site: www.tomah.va.gov

- *Inpatient and outpatient services*
- *Medical care, mental health care, substance abuse treatment, dental care, and socialization and support programs*

Area Served: Adams, Clark, Crawford, Jackson, Juneau, La Crosse, Lincoln, Marathon, Monroe, Portage, Price, Taylor, Trempealeau, Vernon, Waushara, and Wood Counties in Wisconsin; Houston County in Minnesota

Veterans Crisis Line..... (800) 273-8255 then press 1,..... or send a text message to 838255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides a suicide prevention service available to veterans in emotional crisis who are seeking help*

Vet2Vet..... (877) 838-2838

Internet Web Site: www.vet2vetusa.org/

- *Provides a veterans' peer support line*

MILITARY FAMILIES

Military OneSource..... (800) 342-9647

Internet Web Site: www.militaryonesource.mil

- *Helps military personnel and deployed civilians and their families to find help with every aspect of military life*

SPANISH SPEAKING

Spanish Speaking Hotline - Kristin Brooks Hope Center – National Hopeline Network..... (800) 784-2432

Internet Web Site: www.hopeline.com

- *Provides telephone crisis counseling and suicide intervention for people who speak Spanish*

OTHER SPECIAL POPULATIONS

For information about resources for other special populations (individuals with disabilities, senior citizens, Native Americans, members of the Hmong Community, or other special populations) contact Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 or visit the Web site at www.greatrivers211.org

SUPPORT GROUPS

Survivors of Suicide Support Group (La Crosse)..... (608) 633-3135

- *For families and friends who have lost a loved one to suicide*

Support Group for Families of People with Mental Illness (La Crosse)..... (608) 779-1554

- *For families and friends of the chronically mentally ill and other interested persons*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – La Crosse*

Depressed Anonymous (La Crosse)..... (608) 791-5295 or (608) 794-4393

- *For individuals who deal with depression*

Support Group for Persons with Mental Illness (Viroqua)..... (608) 637-8143

- *For people with chronic mental illness, their families and friends*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – Vernon County*

NAMI Support Groups (Winona)..... (507) 459-3475 or (507) 494-0905

- *For adults with mental illness including depression, schizophrenia, bipolar disorder, anxiety disorders, and other mental health problems; also offers a support group for families and friends*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – Winona County*

Mental Health Related Support Groups for Veterans..... (800) 827-8662, ext. 63301

- *Various groups sponsored by River Valley Integrated Health Center*

Mental Health Related Support Groups for Veterans..... (608) 782-4403

- *Various groups sponsored by La Crosse Vet Center*

Wellness Recovery Support Groups (La Crosse)..... (608) 785-9615

- *For anyone who has a mental illness, as well as family and friends*
- *Sponsored by Independent Living Resources*

MENTAL HEALTH DROP-IN CENTERS

Coulee Council on Addictions Resource Center..... (608) 784-3939

921 West Avenue, La Crosse

- *Provides a chemical-free social/recreational atmosphere for substance abusers in recovery*

Area Served: La Crosse, Monroe, Trempealeau and Vernon Counties in Wisconsin; Houston County in Minnesota

Family and Children's Center – Viroqua Office – The Other Door..... (608) 637-7052

1321 North Main Street, Viroqua

- *Provides a chemical-free social/recreational atmosphere for positive networking opportunities*

Area Served: Vernon County

Hiawatha Valley Mental Health Center Peer Support Network..... (507) 454-4341

252 West Wabasha, Winona

- *Provides a drop center with social and recreational activities*

Area Served: Houston, Wabasha, and Winona Counties in Minnesota and Buffalo and La Crosse Counties in Wisconsin

RAVE Mental Health Drop-In Center (Recovery Avenue)..... (608) 785-9615

1806 State Street, La Crosse

- *Provides social and recreational activities; staffed by mental health consumers*

Area Served: La Crosse County

COUNSELING AND RELATED RESOURCES

There are a number of resources for people who are seeking assistance with life concerns as well as for people who have ongoing mental health concerns. These include:

- **Area counseling agencies providing individual or family counseling regarding a variety of concerns,**
- **Agencies providing ongoing mental health and psychiatric management services**
- **Department of Human Services in each county**

Some of these services are available for free and many agencies offer their services based on a sliding fee scale or can bill Medical Assistance or other insurances. Great Rivers 2-1-1 can provide information about and referrals to these and other supportive services. ***Contact Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 or visit the Web site at www.greatrivers211.org . The Great Rivers 2-1-1 line is available 24 hours/day, 7 days/week including all holidays.***

MEDICAL ASSISTANCE PROGRAMS

There are government programs which provide health care coverage ***(often including mental health care)*** *for low income people. With the implementation of the national Affordable Care Act, many options are changing. For updated information see:*

www.healthcare.gov

Wisconsin:

BadgerCare Plus *provides coverage for pregnant women, children, individuals and families meeting eligibility criteria. For information or to apply contact:*

Maternal and Child Health Hotline..... (800) 722-2295

Or

Visit the Web site at www.badgercareplus.org. This Web site provides information and also allows people to enter the ACCESS Web site where they can check to see if they are eligible for BadgerCare Plus or other assistance programs and apply for any of these programs directly online.

Minnesota:

Medical Assistance *provides coverage for children and families, pregnant women, senior citizens, and people with disabilities meeting eligibility criteria.* ***MNSure*** *provides coverage for children and families, pregnant women, and adults without children meeting eligibility criteria. In addition there may be other resources to provide some limited medical care coverage assistance for certain populations, including some non-citizens. For information about any of these programs contact the local county or:*

Minnesota Department of Human Services..... (855) 366-7873

Minnesota Department of Human Services Web site..... www.applymn.dhs.mn.gov

Iowa:

Various ***Medical Assistance*** programs *and* ***HAWK-I*** *provide coverage for eligible populations in Iowa. For information about any of these programs contact the local county or:*

Iowa Department of Human Services..... (800) 972-2017

Online Application for State of Iowa Services (OASIS)..... www.oasis.ia.gov

ADDICTIONS HELP

Many health care providers and counseling agencies offer help for addictions. For more information about specific services contact:

Great Rivers 2-1-1..... 2-1-1 or (800) 362-8255

Internet Web Site: www.greatrivers211.org

ALCOHOL AND OTHER DRUGS

Alcoholics Anonymous (AA) La Crosse Area Intergroup..... (866) 491-8004

Internet Web Site: www.aalacrosse.org

- *Twelve Step support groups for people with alcoholism*

Alcoholics Anonymous (national hotline)..... (212) 870-3400

Internet Web Site: www.aa.org

- *Twelve Step support groups for people with alcoholism*

Al-Anon Family Groups (national hotline)..... (888) 425-2666

Internet Web Site: www.al-anon.alateen.org

- *Twelve Step support groups for families and friends of people with alcoholism*

Cocaine Anonymous World Service Office..... (800) 347-8998

Internet Web Site: www.ca.org

- *Provides confidential assistance, information and referral, education and services to people of all ages dealing with cocaine and other mind-altering substance3s*

Coulee Council on Addictions (La Crosse)..... (608) 784-4177

Internet Web Site: www.couleecouncil.org

- *Provides confidential assistance, information and referral, education and services to people of all ages dealing with substance abuse and other addictions*

Area Served: La Crosse, Monroe, Trempealeau and Vernon Counties in Wisconsin; Houston County in Minnesota

Family Empowerment Network Information Line..... (800) 462-5254

Internet Web Site: www.pregnancyandalcohol.org

- *Toll free information number for women and the providers who work with women of childbearing age who are looking for information about women and alcohol, alcohol and pregnancy, and related issues*

La Crosse County Human Services Department – Integrated Support & Recovery Services...(608) 784-4357

Area Served Includes: La Crosse County

Note: *Substance abuse services vary by county; call Great Rivers 2-1-1 for information about other counties.*

Narcotics Anonymous (national hotline)..... (818) 773-9999

Internet Web Site: www.na.org

- *Twelve Step support groups for people with addictions*

Substance Abuse and Mental Health Services Administration (SAMHSA)..... (800) 662-4357

Internet Web Site: *www.samhsa.gov*

- *Helpline and searchable database of substance abuse treatment options*

GAMBLING

Gamblers Anonymous (national hotline)..... (855) 222-5542

Internet Web Site: www.gamblersanonymous.org

- *Support groups for people with gambling addictions*

Gamblers Anonymous – Gam-Anon La Crosse Area..... (608) 784-4177

Internet Web Site: www.couleecouncil.org/supportgroups.html

- *Support groups for people with gambling addictions*

Gam-Anon (national hotline)..... (718) 352-1671

Internet Web Site: www.gam-anon.org

- *Information and support for families and friends of people with gambling addictions*

Iowa Gambling Treatment Program..... (800) 238-7633

Internet Web Site: www.1800betsoff.org

Minnesota Problem Gambling Helpline..... (800) 333-4673

Internet Web Site: www.getgamblinghelp.com

National Council on Problem Gambling..... (800) 522-4700

Internet Web Site: www.ncpgambling.org

Wisconsin Council on Problem Gambling..... (800) 426-2535

Internet Web Site: www.wi-problemgamblers.org

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Happiness

David Mays, MD, PhD
dvmays@wisc.edu

Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

What Is Mental Health?

- What is mental health? Is mental health like physical health? Being average? Better than average? Being content with what you have? Striving to be improve?

What is Physical Health?

- Physical Health
  - 1) Optimal functioning of bodily systems
  - 2) Freedom from disease
  - 3) Energy, stress management
  - 4) Healthy lifestyle and environment
  - 5) Productive engagement with the world
  - 6) Physical joy

The Right Stuff

- The most intense study of what constitutes positive physical and mental health came in the early 1960's with the beginning of the Mercury Space Program.

The Right Stuff: The Seven Mercury Astronauts

- Exemplary work records
- Competent at loving (intact, happy, small-town families)
- Adventurous, but unusually few accidents, even before becoming pilots
- Could tolerate close interdependent association or extreme isolation

The Right Stuff

- They trusted others
- They did not complain under discomfort
- Emotions, positive and negative, were strongly experienced
- They were not introspective and seldom dwelled on their feelings, but could describe them if asked to
- Aware of the feelings of others

The Right Stuff

- They avoided interpersonal conflict
- Their group score on the neuroticism scale of the Maudsley Personality Inventory has been described as the lowest of any group reported in the literature. (Neuroticism is a personality trait characterized by instability of mood, anxiety, aggression, etc.)

Mental Health

- 1) Optimal functioning of the brain
  - Above average functioning – 91-100 on the old GAF scale
- 2) Freedom from disease
  - Mental illness, dementia
- 3) Energy, stress management
  - Resilience

Mental Health

- 4) Healthy lifestyle and environment
  - Challenge, meaning, connection
- 5) Productive engagement with the world
  - Social-emotional intelligence, maturity
- 6) Joy
  - Happiness

Promoting Brain Health

- Stop smoking: smoking doubles the risk of dementia. Stopping smoking in midlife cancels the risk. Smoking also impairs name and face recall.
- Avoid illicit drugs, head injury, toxins
- Stay socially active: reduces stress and is intellectually stimulating in ways that games and reading are not. (Negative engagement is harmful.)
- Meaningful activity may be especially protective.

Promoting Brain Health

- Exercise: moderately vigorous and regular (walking briskly 5-6 hours/week.) Exercise promotes cardiac health, good lung function, and an increase in neurotropins.
- Eat a Mediterranean style diet: grains, fruits, vegetables, non-saturated fats. Omega-3 fatty acids from fish may be important.
- Moderate alcohol consumption: why?

Promoting Brain Health

- Keep learning: intellectual enrichment stimulate the brain to make more connections and may have greater reserves of cognitive ability to sustain more neuronal loss without problems.
- Manage stress: mild stress results in neurogenesis. but severe chronic stress does not. Cortisol damages neurons.
- Get a good night's sleep: Sleep consolidates memories and reduces cortisol.

Healthy Lifestyle and Environment

- Connection: humans are social animals who are born to connect. It is very difficult to find any examples of people who are healthy physically or mentally who are not connected somehow to another human being.

Social Support and Life Expectancy

- Men and women without ties to others are 1.9 to 3 times more likely to die from ischemic heart disease, cerebral vascular disease, or cancer within a nine year period than individuals with more social contacts.
- The effect of social support on life expectancy appears to be as strong as the effects of obesity, cigarette smoking, hypertension, or level of physical activity.

Biological Research

- Happiness and unhappiness are not on a continuum. We seem to have a positive system and a negative system that operate separately, but can stifle each other. And in terms of evolutionary design, bad is stronger than good.

The Positive and Negative Systems

- Negative
  - Like Velcro
  - Very sensitive
  - Bitter 1:2,000,000
  - I HATE to lose
  - Triggered by poverty
  - 1 negative remark
  - Stronger reaction to negative language
  - Strong and damaging stress response
  - Harder to adapt to
- Positive
  - Like Teflon
  - Not sensitive
  - Sweetness 1:200
  - Winning is OK
  - Money has no effect
  - 5 positive remarks
  - Weaker response to positive language
  - Pleasure response not very physically active
  - Fast adaptation

Defining Happiness

- The Pleasurable Life: Pleasure and Enjoyment
- The Engaged Life: Feeling Good and Flow
- The Meaningful Life: Purpose

The Pleasurable Life

- The pleasurable life consists of experiencing as many pleasures as possible and learning to amplify and savor them.
- Pleasure may range from the basic to the very refined.
- The ability to experience pleasure seems to be very genetic (about 50%.) People who are very social tend to also experience a lot of this kind of happiness.
- Unfortunately, we tend to habituate/adapt very rapidly to pleasure.

Adaptation

- Soon after a major event, we return to normal so we can be motivated again. This is called "Adaptation." Our brains are not trying to make us happy. They are trying to regulate us. "Wanting" is structural. No amount of "getting" can fill it up.
- Our unimaginably successful consumer economy is based on this phenomenon.

US Citizens: "Necessities"

Item	1970	2000
Second car	20%	59%
Second TV	3%	45%
More than 1 telephone	2%	78%
Car air conditioning	11%	65%
Home air conditioning	22%	70%
Dishwasher	8%	44%

The Good Life

- The good life is a life devoted to developing and refining our capabilities. It is an investment in the present in order to improve the future. It involves purposeful engagement, positive self-regard, high quality relationships, and personal growth.
- Two different experiences contribute to the good life:
  - being in a good mood
  - the experience of "flow."
- This kind of happiness is usually what is referred to when writers talk about our happiness "set point." We may be born a cheerful person, or someone who easily becomes engages in "flow."
- Studies show that people who are happy most of the time also tend to be:
  - Optimistic
  - Appreciative
  - Social

The Meaningful Life

- The meaningful life arises when people both know their strengths and use them not in a self-focused way, but in the service of something "larger" than themselves. The boundary between self and other is permeable. It is, in many respects, the pursuit of virtue.

Generosity

- Increase in happiness by having a income increase from $20,000 to $80,000: 16%
- Increase in happiness from never volunteering to volunteering once a week: 16%.
- 2008 study: employees who gave more of their bonus money to charity reported greater happiness than those who gave less.

What makes for an overall satisfying life?

- After interviewing thousands of subjects, it appears that "pleasure" has only a marginal contribution to overall life satisfaction. "Flow" contributes much more strongly. "Meaning" has the largest contribution.
- A survey of 30,000 American households found that those who gave to charity were 43% more likely to say they were "very happy" than those who did not give.

Happiness Traps

- 1) Money
- 2) Family
- 3) Not taking into account impact bias and adaptation – nothing will be as good as we hope
- 4) Not taking into account our psychological immune system – nothing will be as bad as we are afraid of
- 5) Trying to maximize our options
- 6) The self-esteem movement
- 7) The comparing mind

Can Money Buy Happiness?

- The historical research says money can buy happiness and it already has.
- Throughout history, most people have been racked by illness, the desperate hunger of their children, continual drudgery, and the threat of violent animals.
- However, data suggests that once you have enough, more money does not make much difference.

Money and Happiness

- People who make $50,000/yr are a lot happier than those who make $10,000. But people who make $5 million/year aren't that much happier than those who make $100,000/yr.
- The data says that if you are poor, a little money can buy a lot of happiness. But if you are rich, a lot of money can only buy you a little more happiness.

What Would Make You Happy?

- Most people believe that having children would make them happy. Most parents would say that some of their best moments of happiness involved their children, but on a day-to-day level, people aren't particularly happy when they're interacting with their children. Women looking after their children are significantly less happy than when they're watching TV. (Children are hard work!)

Some Myths About Choice

- 1) You will be happier and perform better if you make your own choices: "Be true to yourself."
- This may be true in American culture today, but it is not necessarily true for everyone.

Myths About Choice

- 2) The more choices you have, the more likely you are to get what you want, and the happier you will be.
- Americans have become the most skilled people in the world at spotting differences between similar items, in order to pick out the "best." In fact, studies show that when people have ten or more options, they tend to make bad choices.

Are Options Good For Us?

- The more choices we have, the more likely we are to regret our choice. It is easy to idealize the choice we did not take. We experience an "escalation of expectations."

Comparing Mind

- We underestimate our "comparing" mind. We are always looking at those around us and comparing our circumstances to theirs. What makes people happy is not wealth, for instance, but relative wealth. Most of us would feel happier making $50,000/yr in a job where the average salary is $40,000, than making $60,000/yr in a job where the average is $70,000.

The Biggest Trap

- The biggest trap is thinking of happiness as a permanent state. Happiness is a momentary experience. You can't *be happy* all the time. No one would like you. Happiness shouldn't be a goal.
- But being mentally healthy is a reasonable goal. What do we know about how to do that?

The Goal: Not Just Happy, but Mentally Healthy

- 1) Optimal functioning of the brain
  - Above average functioning – 91-100 on the old GAF scale
- 2) Freedom from disease
  - Mental illness, dementia
- 3) Energy, stress management
  - Resilience

Mental Health

- 4) Healthy lifestyle and environment
  - Challenge, meaning, connection
- 5) Productive engagement with the world
  - Social-emotional intelligence, maturity
- 6) Joy
  - Happiness

Increasing Pleasure: Single Task

- You can't fully pay attention to multiple things. (People who multitask are not doing anything as well as people who single task. In fact, the posterior lateral prefrontal cortex delays one task while you are working on another. We do one thing at a time.)

Increasing Pleasure: Set a Happiness Trap for Yourself

- Trying to feel happier feels forced and may backfire. Instead of trying to boost your happiness in the moment, maximize your odds of feeling good by planning activities that you know make you happy. In short, plan to do those things that make you feel good. Like taking a walk...The natural world makes most humans happy. Almost everyone enjoys listening to music.

Enjoy the Past

- You can also savor things that happened in the past. Participants in one study who spent ten minutes, twice a day reminiscing about a pleasurable event felt happier during the week than those who spent the time thinking about current issues in their lives. *But don't overanalyze*, which interferes with the effect. Looking at pictures, listening to music, re-reading letters all were helpful.

Hold on to Good Experiences for 20 Seconds

- Let yourself be happy when you have a good moment! Aversive events get stored more quickly in memory, and are more rapidly recalled. Positive events are stored through the standard memory systems and need to be held in conscious awareness for 10-20 seconds for them to be coded and held onto.
- Help positive events become positive experiences by paying extra attention to them. Hold them in consciousness longer. Savor them so they sink in.

A Little More About This…

- Negative events have more salience for us than positive events and are coded faster. If the typical "moment" in a human's consciousness is ~3 seconds, it is easy to imagine that as we construct the "remembering self" (our story), we will preferentially be using negative events. Could this be the source of all the negative self-talk that most of us have?

Increasing Pleasure

- The brain is wired to things that are novel. Adaptation means that frequent small pleasant events have a bigger impact than occasional large events.
- Slow down: time affluence predicts happiness better than monetary affluence. Eliminate some of the less enjoyable ways you spend your time. Taking a break improves focus.

Increasing Pleasure

- Get enough sleep. People who are sleep deprived are more negative and more emotionally vulnerable to stresses.
- A big part of pleasure is looking forward to something. Savor that.

Maximizers vs. Satisficers

- Maximizers are like perfectionists – they need to be assured that every purchase, every decision, is the very best that could be made. They are never satisfied.
- Satisficers have criteria and standards, but will be satisfied when those criteria are met, rather than wondering if there is something better is around the corner.

Maximizers vs. Satisficers

- In a 2008 study conducted by U Minn at a mall, having to make more choices interfered with participants ability to pay attention and solve arithmetic problems.
- In a Columbia/Swarthmore study comparing maximizers and satisficers during a job hunt, the maximizers found jobs that paid 20% more than the satisficers, but had more bad experiences during the job hunt, and ended up less happy with their jobs.

Satisficers are Happier than Maximizers

- Work on being a "Satisficer" rather than a "Maximizer."
  - Restrict your options (two stores, e.g.)
  - Realize when a choice has met your core requirements
  - Consciously limit the time spent on wondering about other options that you have missed.

Expanding the Social World

- People with 5+ friends outside of immediate family are happier than those with fewer friends. Work toward spending more time socializing.
- Can pets increase your happiness?

Human-Companion Animal Interaction

- Most pet owners view their pets as enhancing the quality of family life by minimizing tension between family members and enhancing the owner's compassion for living things. At least one study found that dog owners were as emotionally as close to their dogs as to their closest family member. 33% were actually closer than to any other human family member.
- One study found post-MI survival rates higher for pet owners than non-pet owners. Another study of 5,700 people showed male pet owners had significantly lower systolic blood pressure, triglyceride and cholesterol levels.

Money Can Buy Happiness!

- (if you give it away)

Evaluating Aid Sites

- Charitynavigator.org
- Givewell.net
- Thelifeyoucansave.com
- Donorschoose.org

Do your Optimism and Gratitude Exercises

- Pessimists who spent one week writing down experiences when they felt good about themselves and others were happier than controls 6 months later.
- In one 10 week study, keeping a gratitude journal of 5 things they were thankful for, once a week, increased happiness levels, reduced doctors visits, and helped people exercise (!) in participants.

Happiness as a byproduct of living your life is a great thing. But happiness as a goal is a recipe for disaster.

Barry Schwartz, Swarthmore College

"It is only a slight exaggeration to say that happiness is the experience of spending time with people you love and who love you."

- Daniel Kahneman, Nobel Laureate

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Men and Depression

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

"I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on earth.

Whether I shall ever be better, I cannot tell: I awfully forebode I shall not. To remain as I am is impossible. I must die or be better, it appears to me."

Robert Wilson, fellow legislator of Lincoln's, 1836

"He (Lincoln) told me that although he appeared to enjoy life rapturously, still he was the victim of a terrible melancholy. He sought company, and indulged in fun and hilarity without restraint. Still when by himself, he told me that he was so overcome with mental depression, that he never dare carry a knife in his pocket. As long as I was intimately acquainted with him, he never carried a pocket knife."

Depression

- Depression is a commonly experienced mood and a syndrome. A clinical depression is distinguished from a depressed mood by the intensity and pervasiveness of its symptoms. Depressed people are usually not able to relate to others and may be able to express only a limited range of emotions. They are frequently obsessively focused on themselves and how they are feeling moment to moment. In a primary care setting the following complaints may identify depression: sleep disturbance, fatigue, somatic complaints.

An Alternative Description to DSM

- The present criteria for "Major" Depressive Disorder was the result of a compromise between scientists and analysts in writing the DSM-III. Originally, major and minor types of depression were proposed, but since the analysts worked with "minor" depression, and were afraid they would not be reimbursed for treatment if it was called minor, all the criteria were subsumed into Major Depression. What has been lost is the phenomenology of depression.

The Spectrum of Major Depression
(Ghaemi 2012)

- Melancholic
- Neurotic
- Mixed
- Pure

Melancholic Depression

- Severe and generally unassociated with anxiety
- Psychomotor retardation
- Marked anhedonia
- No reactivity – patients are not labile and are unresponsive to psychological stressors. (Bad events don't make them feel worse because they can't feel any worse.)
- Episodic, not chronic, but lengthy
- More common in bipolar depression than unipolar
- High suicide risk
- Tricyclic antidepressants, Electroconvulsive therapy

Neurotic Depression

- Mix of mild depression and mild anxiety
- High degree of sensitivity to psychosocial stressors
- Chronic, not episodic, although they may be easily pushed into a major depressive episode by stress
- Probably more temperament than disease
- Does not respond to antidepressants any more than to placebos

Mixed Depression

- Major depression with 1-3 manic symptoms
- Core features: irritability, agitation, mood lability
- More common in bipolar disorder, but frequently present in major depressive disorder
- Recent research indicates that more people with mood disorders have mixed symptoms than purely depressive or manic (at least 40% of the total)
- Antipsychotics are more effective than antidepressants

Pure Depression

- Some mood reactivity, some interests, somewhat functional (not melancholic)
- No mania, little or no anxiety (not mixed)
- Episodic (not neurotic)
- The new antidepressants may be the most effective in this group.

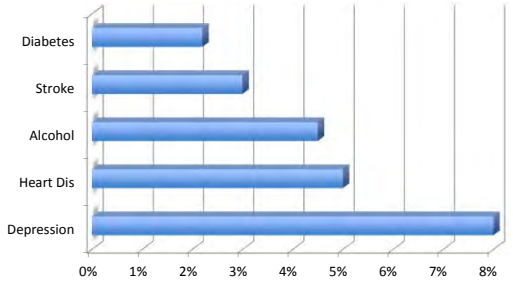
Demographics

- Depression is the fourth leading cause of disease burden worldwide, 1st in the United States. Lifetime prevalence may be 7-12% of men, 20-25% of women. High risk groups include Native Americans (19.17%) and Caucasians (14.58%). Asians are at lowest risk (8.77%).
- There is high comorbidity with anxiety disorders (36%) and personality disorder (37%).
- Mortality is high. 46% wish to die. 9% report a suicide attempt. Risk of suicide death is 20x higher – 15% lifetime risk. 30-70% of suicides have a depressive disorder.

Impairment

- 44% of depressed people have some sort of functional work impairment, 11% are unable to work altogether. In 2020, major depression will be second only to heart disease in the amount of disability suffered.
- Cardiac clients have 4x greater risk of depression and depression a month after a heart attack is the best predictor of MI in next year - the risk is the same as being a smoker – 5x more likely to die than healthy peers.

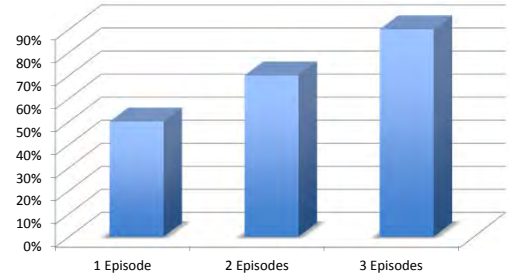
Causes of Disability



Natural History

- Depression is a lifelong illness, likely to relapse within a few months after the first episode.
- Average age of onset is late 20-40 years old. Symptoms develop over days or weeks.
- Prodromal symptoms include anxiety, panic, phobias, low grade depression.
- Episodes last from 6 to 24 months.
- There is strong evidence that sub-syndromal continuation of symptoms represent a continuation of the illness, and will lead to relapse.

Risk of Recurrence of Depression (*DSM-IV-TR*)



Depression and Clinical Practice

- In clinical practice, the diagnosis of “depression” is used across a wide variety of clinical presentations of depressed mood. It can encompass major depressive disorder, depression in bipolar disorder, dysthymia, reactive depression, an overall sense of dysphoria or pessimism, bereavement, and the depression found in personality disorders, particularly borderline. It may be a sign of many different disorders, similar to “fever” or “inflammation” in medical practice.

Symptoms

- Affective
  - Depressed mood
- Vegetative
  - Weight loss or gain
  - Insomnia or hypersomnia (insomnia has a bidirectional relationship to depression – a cause and an effect)
  - Decreased sex drive
- Behavioral
  - Psychomotor retardation or agitation
  - Fatigue
  - Diminished interest or pleasure in most activities

Symptoms

- Cognitive
  - Feelings of worthlessness or guilt
  - Diminished ability to think and concentrate
  - Poor frustration tolerance
  - Negative distortions
  - Affective agnosia and apraxia
- Impulse Control
  - Recurrent thoughts of suicide, homicide, or death
- Somatic
  - Headaches, stomach aches, muscle tension
- Chronic Painful Physical Conditions

Symptoms

- Clients with depression have difficulties with interpersonal relationships, largely related to problems with emotional perception and executive function. They misidentify happy facial expressions as sad, for instance.
- There is evidence of mood state dependent learning - clients don't remember ever feeling good, increasing the risk of suicide. These memories can be retrieved with proper prompting and cueing.

Comorbidities

- Social anxiety disorder is a major risk factor
- Comorbid personality disorder confers worse prognosis and treatment response
- Obesity and metabolic syndrome – bidirectional
- Coronary artery disease
- 65% increase in risk for diabetes
- Secretion and production of proinflammatory enzymes

Gender Issues

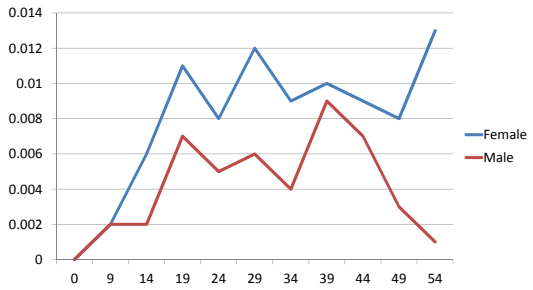
Depression is "a fixed melancholy."
Emily Dickinson

Depression is "a rage spread thin."
George Santayana

Gender Issues

- Women are twice as likely to be depressed as men (1/5 vs. 1/10). The gender difference begins at 10 and continues until the mid 50's. Social and hormonal influences contribute to making adolescence a difficult transition for girls. Estrogen may boost levels of cortisol and inhibit GABA.
- Menopause is strongly associated with new onset depression.
- College education, being in the first marriage, working outside the home lowers risk. Single mothers have 2x the depression risk as mothers with partners.

Hazard Rate for Depression



Women

- More likely to describe themselves as sad or depressed with more symptoms and higher degree of distress
- More "reverse" symptoms (hypersomnia, increased appetite, somatization)
- Friendship networks are larger, which buffers and creates stress.
- Marriage is protective for men, but not for women.

Gender

- Women are more likely to seek healthcare for depression, in part, because women enter the healthcare system more frequently than men due to seeking birth control and/or pregnancy. If men are more likely to attribute their depression to finances, etc., they are less likely to view the healthcare system as the place for help.

Why the Gender Difference?

- Genes: Heredity may account for ~40% of the risk of major depression. Certain genetic mutations that are associated with the development of severe depression occur only in women.
- Hormones: The gender difference begins at puberty. Hormonal changes that accompany menstruation bring on mood changes. Some women are vulnerable to depression after childbirth or menopause. But it has not been proven that hormonal changes significantly alter mood in large groups of women.

Why the Gender Difference?

- Stress: Women are more likely than men to say that they are under stress. Some studies indicate that women are more likely to become depressed after a stressful event. Women are more likely to experience certain kinds of stress, such as child sexual abuse, sexual assault, and domestic violence. Women are more likely than men to be caregivers. Women are also more likely to live in poverty than men, and be single parents.
- Exercise: Women are less likely to get exercise and be in poor physical health than men.

Gender

Am J Psychiatry, April 2014

- In a large, opposite sex twin study, the following risk factors were defined for each gender:
  - Women: deficiencies in caring relationships and interpersonal loss
    - Neuroticism, divorce, absence of parental warmth and social supports, lack of marital satisfaction
  - Men: failure to achieve expected goals and lowered self-worth
    - Childhood sexual abuse, conduct disorder, drug abuse, financial, occupational, legal stress

Men

- Testosterone may make boys more susceptible to seizures (and possibly autism) due to the increase in GABA, but may protect them from depression later on.
- SSRI's may work better in the presence of estrogen.
- They are less likely to seek help and 4x more likely to die of suicide than women, although they attempt suicide 3x less often.

Symptoms in Men

- Men are more likely
  - to lose weight when depressed
  - to show OCD symptoms rather than simply anxiety
  - to abuse substances
  - to show anger and irritability
  - to increase risk taking

Suicide Epidemiologic Risk Factors

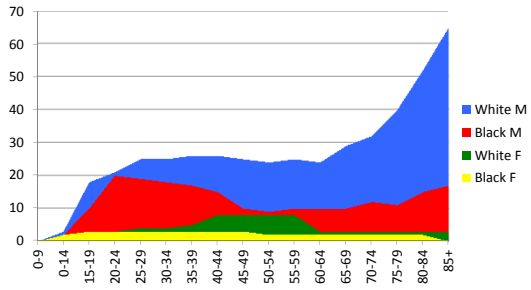
- Gender, Age, and Race
- Marital Status
- Family History
- Mental Illness History
- Newness in Treatment Program
- Time of Year
- Rural vs. Urban
- Natural/Unnatural Disasters
- The Media

NESARC Data (n=43,093) Suicide Findings

- Among depressed people:
  - Highest suicide attempts – Hispanic, Latino, younger age, low income
  - Comorbidity with any anxiety disorder, personality disorder, substance abuse
  - In men, depression + dependent personality disorder (75% will make a suicide attempt)
  - In women, antisocial personality disorder
  - Most predictive symptom: feeling worthless

Gender, Race, and Age

Natl Center Health Statistics, 2006



Gender

- Gender differences in suicide deaths have complicated attempts to understand the epidemiology of suicide. Women have low suicide mortality, but a higher incidence of the two most significant risk factors – depression and suicide attempts.
- Risk factors of increasing age, single marital status, physical illness, stressful life events, unemployment, and low socioeconomic status apply only to men.

Gender

- The reason for this gender difference is not known. It is suggested that in men, higher rates of substance abuse, violence, and greater social expectation that a real man will "succeed" in a suicide attempt contribute to men using more lethal means than women.
- In contrast, women tend to exhibit more help-seeking behavior, have more social connectivity, have more "permission" to make non-fatal attempts, and may assume more responsibility for the feelings of children and family members

The Problem

- Suicide rates have not decreased in the last decade, or in the last 110 years. Compare this with progress made in other areas of public health: breast and skin cancer, HIV, automobile accidents, etc. where we have seen a decrease in death rates from 40-80%.

The Problem

- Preventing suicide is not easy. The base rate of suicide is low creating a number of statistical and research problems. Our current approach of using epidemiologic risk factors has no clinical utility. Even the highest odds ratio is not informative at an individual level. (The best predictor is a previous suicide attempt, but 60% of suicides occur on the first attempt.) Furthermore, decades of research have failed to identify any new predictors. We have no biological markers.

The Problem

- People who are at risk of suicide do not seek help. 80% of people who die of suicide have seen a provider prior to their attempt, but did not identify themselves as suicidal, largely because they think they do not need help.
- Treatment is often not optimal. Community treatments (gatekeeper training, school programs) are not coordinated with medical interventions (treatment of mental illness, follow-up.)

The Problem

- Cardiovascular disease and cancer research have studies that include hundreds of thousands of patients. We need that kind of power to determine effective treatments.
- In order to study short-term risk, real time monitoring may provide helpful ideas. Less than 1% of risk factor studies look at the week before the suicide.

The Problem Christensen JAMA May 2016

- Mobile phones
- Certain phrases and use of personal pronouns in blogs\digital footprints on Twitter – machines can learn to detect disturbing tweets.
- Data mining may help uncover risk factors
- Facial and voice characteristics
- Social media can facilitate help seeking and peer support. Suicide prevention apps and websites can deliver assessment and information.

Mariano Sigman, PhD

Shifts in Our Thinking About Depression

- From neurotransmitters to neuroplasticity
  - Neurogenesis, dendritic pathology…
- From chemical imbalance to neuro-inflammation
- From serotonin and norepinephrine to glutamate
- From oral to parental administration
- From delayed efficacy to immediate efficacy
- From pharmacotherapy to neuromodulation

"Network Model"

- Hypothesis: the problem is not so much with neurotransmitter inadequacy, but rather with networks of cells that are dysfunctional.
- A 2012 meta-analysis of brain scan studies found high baseline activation in the pulvinar, a large nucleus in the thalamus. This structure is part of a fast, unconscious processing stream for priming behavior in the face of a threat, as well as for focusing emotional attention and awareness.

Network Theory

- The amygdala, dorsal anterior cingulate cortex, and insula are all overactive to negative stimuli.
- These data are consistent with the hypothesis that negative cognitive biases play a crucial role in the onset and maintenance of major depression.
- These sensory inputs fail to propagate to the dorsolateral prefrontal cortex, which would ordinarily allow the individual to appraise and correct this negativity.

Bottom Line

- Current imaging research indicates a bias of attention to negative emotional stimuli and a lack of recognition of positive emotional and rewarding stimuli.
- There is increased activity supporting emotion processing and reduced activity in neural systems supporting regulation of emotions (dorsolateral prefrontal cortex.)

Free Depression Outcome Scale

- Patient Health Questionnaire-9 (PHQ-9) www.depression-primarycare.org/forms/phq_9/

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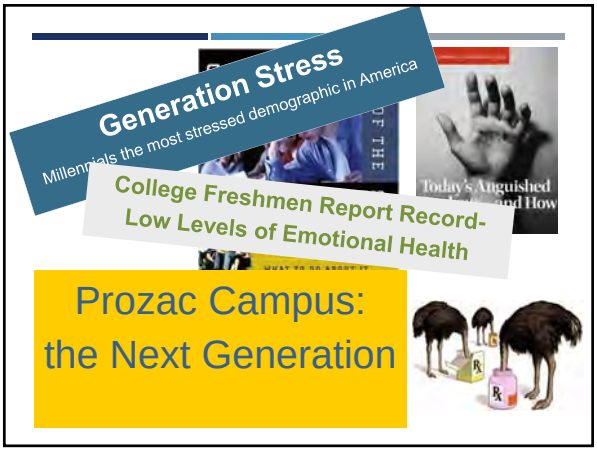
THE ROLE OF RESILIENCE IN SUICIDE PREVENTION: WORKING WITH COLLEGE STUDENTS & OTHER EMERGING ADULTS

DR. GRETCHEN REINDERS
DIRECTOR, UWL COUNSELING & TESTING CENTER

LEARNING OBJECTIVES

1. Learn about trends specific to college student and emerging adult mental health.
2. Review of clinical assessment measures and treatment interventions specific to resilience.
3. Identify strategies for building resilience and learn how to apply these strategies for suicide prevention work with college students and emerging adults.



HOW THIS NARRATIVE IMPACTS EMERGING ADULTS

- First, let's define emerging adults
  - Not a new concept
  - The developmental period "from the late teens through the twenties, with a focus on ages 18-25."
  - Distinct identity development, different from adolescence or young adulthood, especially for individuals in industrialized countries.
  - Future is yet to be decided.
- What does it mean to reach "adulthood"?
  1) Responsibility for one's self
  2) Making independent decisions
  3) Financial independence

SO, HOW DOES THIS NARRATIVE IMPACT EMERGING ADULTS?

- Impact on educators who are teaching emerging adults:
  - Concern that students will become depressed or hostile with lower grades
  - Intolerance for the students' distress and/or assuming that they simply cannot cope when the students have very real and valid concerns
- Impact on employers of emerging adults:
  - Belief that they are ill-prepared for the "real world" or work
  - Over-emphasis on generation gap rather than creative methods of having multiple generations working alongside one another
- Impact on emerging adults themselves:
  - Individual's belief that they cannot tolerate distress, cannot problem-solve, cannot survive adverse situations
  - Seeking immediate help for perceived crises that could likely be solved on their own
  - Not seeking help because they do not get a quick answer or because they think the helping professional sees them as incapable

MERITS OF THIS NARRATIVE?

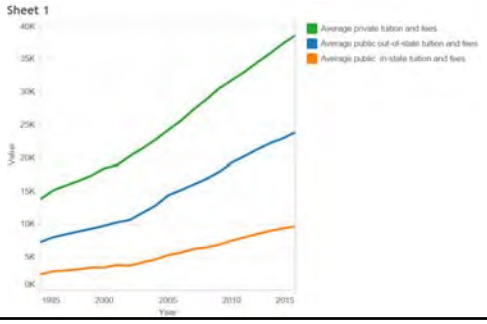
Are today's emerging adults really that different than those in the 70's, 80's, 90's?

- Consider the changing demographics of students
- Parental involvement
- Cost
- Achievement gap
- Global, national, and local events that shape worldview
- Stigma reduction, willingness to seek help
- Some things are consistent, others are different…

HELICOPTER AND SNOW PLOW PARENTING

Message sent to young people: you are not capable of making good decisions, of taking care of yourself

COST OF COLLEGE



SOCIAL MEDIA

MENTAL HEALTH TRENDS OF COLLEGE STUDENTS

- Today about 13 percent of college students enter into college having been diagnosed with a mental health condition.
- Research conducted by the National Institute of Mental Health shows that half of all lifetime cases of mental illness begin by age 14; three-fourths by age 24.
- Students are more likely to be referred and more willing to seek help
- Students who use campus counseling resources while at college are more likely to stay in school than students who do not use these services.

BY THE NUMBERS

Presenting Concern of CTC clients	%
Stress/Stress management	63%
Anxiety/fears/worries	60%
Depression/sadness/mood swings	60%
Problems related to school	45%
Low self-esteem/confidence	37%
Sleep difficulties	26%
Friends/roommates/dating concerns	26%
Eating behavior/body image	19%
Shyness/social discomfort	17%
Suicidal thoughts/urges	11%

NCHA data, specific to UWL respondents	*Any time within the last 12 months*
Felt so depressed that it was difficult to function	30%
Felt overwhelming anxiety	56%
Seriously considered suicide	6.5%
Intentionally cut, burned, bruised, or otherwise injured yourself	5.8%
Felt overwhelmed by all you had to do	91%

WHAT IS RESILIENCE?

"Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress… It means "bouncing back" from difficult experiences (American Psychological Association)

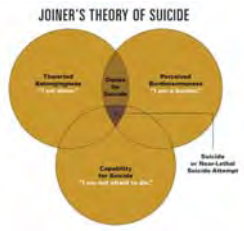
Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone.

RESILIENCE IN ADOLESCENCE AND EMERGING ADULTS

- *Protective factors* have often been proposed promoting/enhancing resilience, and typically fall into three categories:
  - *Individual*
    - coping skills, problem-solving skills, intelligence, internal locus of control ("I can shape my own life"), sense of purpose and goals, self-esteem, social competence and interpersonal communication
  - *Family*
    - secure attachment, direct guidance with encouragement; learning what NOT to do
  - *External/community*
    - caring non-parent adults (teachers, counselors, coaches, ministers, neighbors); positive peer relationships

HOW DOES RESILIENCE RELATE TO SUICIDALITY?

- How do you see these as related concepts?
- Consider Joiner's Interpersonal Theory of Suicide as one example:



HOW WE MIGHT ASSESS RESILIENCE

- Clinicians
- Educators
- Friends and Family

- Interviews & assessments
- Invite dialogue about success and failure, share your stories
- Observe and individual's response to adversity
- Listen for language and use it in your conversations
  - Strengths
  - Sense of agency, hope, etc.

SAMPLE ASSESSMENTS

- Based upon a meta-analysis on resilience measures/assessments (Windle et al., 2011), 3 adult assessments were reviewed to have the strongest psychometric properties:

1. Connor-Davidson Resilience Scale (CD-RISC)
2. Resilience Scale for Adults (RSA)
3. Brief Resilience Scale (BRS)

NOTE: Other scales exist (including a number for children), but many scales were in early development and needed further research – for example, the Child and Youth Resilience Measure (CYRM) for at-risk youth is designed to be a culturally and contextually relevant measure. The manual is available online: http://www.resilienceresearch.org/files/CYRM/Child%20-%20CYRM%20Manual.pdf

CONNOR-DAVIDSON RESILIENCE SCALE (CD-RISC)

- Target population: adults
- Self-report
- Measures 5 dimensions, has 25 items
- Developed for clinical practice to measure stress and coping ability; sees resilience as a personal quality.
- There is a short version developed in 2007 normed on young adults (10 items).

RESILIENCE SCALE FOR ADULTS (RSA)

- Target population: adults (developed in Norway)
- Self-report
- Measures 5 dimensions, has 37 items
- Used to examine protective factors presumed to facilitate adaptation to adversity.
- A 2005 version with 33 items was normed on adults in 20's and 30's.
- There is a short version developed in 2007 normed on young adults (10 items).

BRIEF RESILIENCE SCALE

- Target population: adults
- Self-report
- Measures 1 dimension, has 6 items
- Developed to asses ability to bounce back or recover from stress.

BRIEF RESILIENCE SCALE

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I tend to bounce back quickly after hard times	1	2	3	4	5
I have a hard time making it through stressful events.	5	4	3	2	1
It does not take me long to recover from a stressful event.	1	2	3	4	5
It is hard for me to snap back when something bad happens.	5	4	3	2	1
I usually come through difficult times with little trouble.	1	2	3	4	5
I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ (item average / 6)

SUICIDE RESILIENCE INVENTORY-25 (SRI-25)

- Studies supporting its use in adolescent psychiatric populations and in college students
- Factor analyses indicated support for the three dimensions it measures:
  - Internal Protective Scale
  - Emotional Stability
  - External Protective Scale

HOW WE MIGHT CULTIVATE RESILIENCE

- In ourselves
  - **Make connections with others.**
  - **Avoid seeing crises as insurmountable problems.**
  - **Accept that change is a part of living.**
  - **Move toward your goals. Take decisive actions.**
  - **Nurture a positive view of yourself.**
  - **Keep things in perspective.**
  - **Maintain a hopeful outlook.**
  - **Take care of yourself.**
  - **Reflect**

HOW WE MIGHT CULTIVATE RESILIENCE

- As Clinicians
- As Educators
- As Friends and Family members

- What are your ideas? Success stories?

RESOURCES ON RESILIENCE

- Edutopia resources:
  - http://www.edutopia.org/resilience-grit-resources
- Resilience Project
  - https://undergrad.stanford.edu/resilience
- The Princeton Perspective Project
  - https://perspective.princeton.edu/
- The Success-Failure Project
  - http://successfailureproject.bsc.harvard.edu/
- The Princeton Perspective Project
  - https://perspective.princeton.edu/
- The Mindset Kit
  - https://www.mindsetkit.org/about

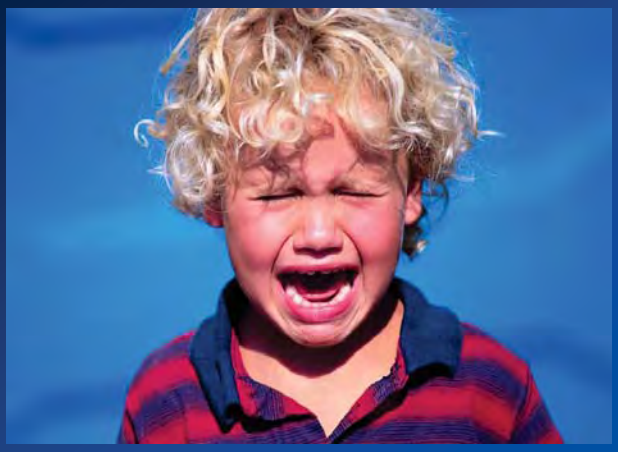
ENDING THOUGHTS…

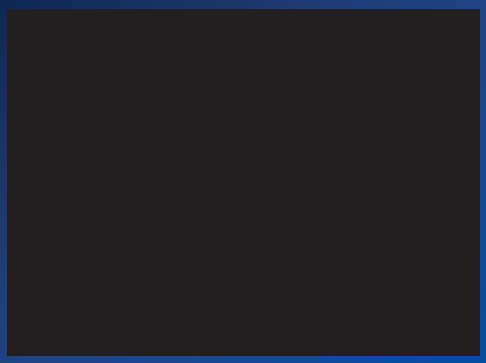
I have learned that success is to be measured not so much by the position that one has reached in life as by the obstacles overcome while trying to succeed.
- *Booker T Washington*

I am not what happened to me, I am what I choose to become.
- *Carl Gustav Jung*

I am not afraid of storms for I am *learning* how to *sail my ship*."
- *Louisa May Alcott*

De-Escalation of Children Crisis





Introduction

- Why are some crises with this (my) child so seemingly out of control?
- Why don't traditional and/ or well intentioned approaches seem to help?
- What does help?

Important Concepts

Trauma

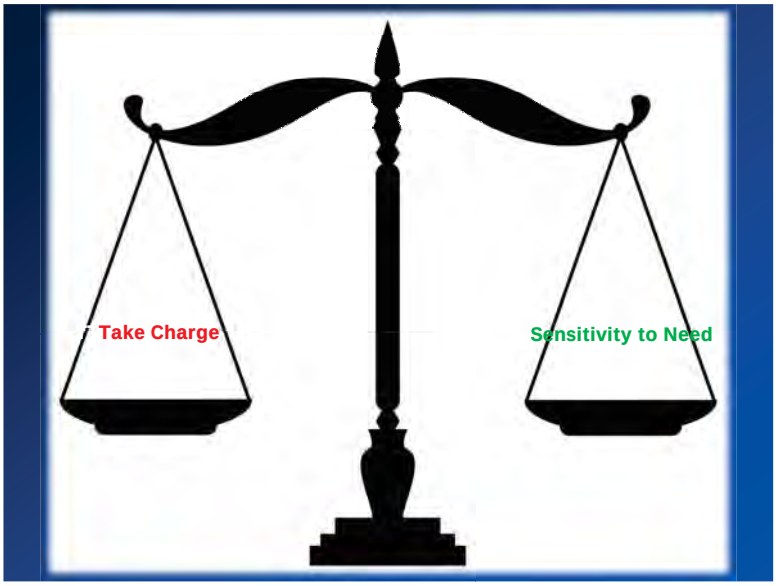
Attachment

Emotional Regulation and Emotional Development

Re-Enactment

Being the Hands

Focusing on Needs



How did that go?

Important Mindsets or "Mantras" to help Us

- **Behavior Management versus Sensitivity to Need (COS)**
- **What's wrong with you versus What happened to you (CPP)**
- **"I'm showing you rather than telling you I have a need"**
- **The Iceberg Metaphor (TF-CBT)**
- **"The Electric Fence"**

Fighting our Internal Battle

- Finding something that you truly value or "love" about someone and fusing with it
- Continually connecting yourself to that place/ space

Respect Should be earned, not demanded.

"I'm In"

- Going in to situations with children and adolescents telling yourself "I want to get this right"

"We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit." E. E. Cummings

What's wrong with you vs. What Happened to you

Banana Peels

2 hour Dysregulation

Behavior and Emotion Regulation Across Development

Re-enactment/ Old patterns

What's wrong with you versus what happened (or is happening) to you?

Did she fail in that interaction?

Was she ever not in charge?

Was she insensitive?

Did she look afraid of him?

Did she seem like she wanted to help him?

Looking at Health 1st

Attachment Theory

Other Evidence Based Models

The importance of natural "attunement"

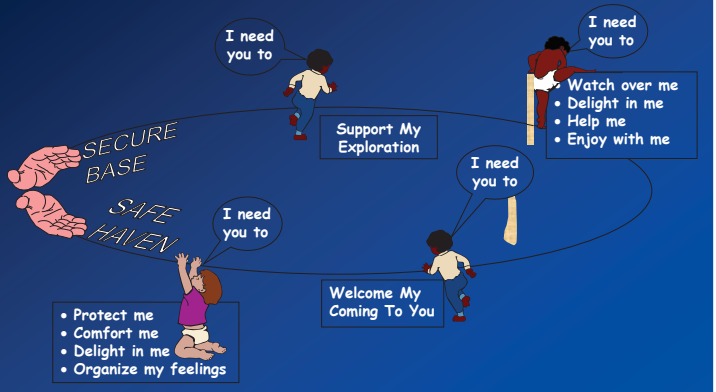
Motivational Interviewing (with everyone)

- Getting yourself out of the way
- Accurate Empathy – how do you know its accurate?
- People have within them enormous untapped potential

Circle of Security

Parent Attending to the Child's Needs

© Cooper, Hoffman, Marvin, & Powell, 1999

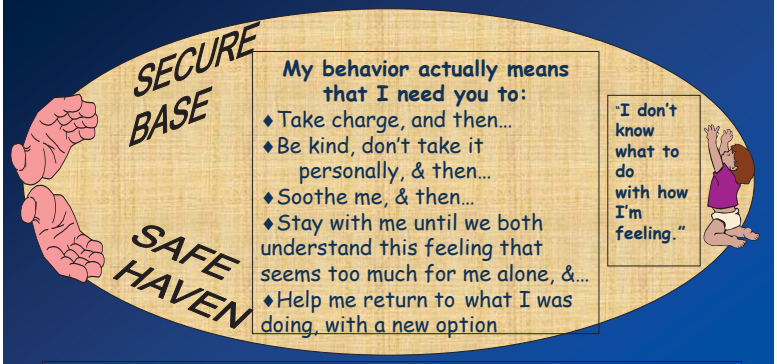


"I'm struggling – and I'm being disrespectful"

Crisis: Divide and Conquer

- **Emotional "allergies" or tensions**
- **Sometimes the interpersonal interaction collectively creates this**

Mom & Dad, when I get difficult (frustrated, demanding, upset, out of control):



CIRCLE OF REPAIR

Helping My Child Trust that Our Safe & Secure Relationship Will (Almost) Always Set Things Right

"She Needs Her Mother"

- Crisis call – with responder, adolescent, mother, local hospital social worker
- Mom from Eastern Block country

Little Miss Sunshine clip

Miscommunication

"If a community values its children, it must cherish the parents" – John Bowlby, MD, Father of Attachment Theory

My Meds (26 year old adult)

"No one understands what you've been through" (22 year old adult)

"From a 45 to a 4" (15 year old boy)

Attunement

The Minnesota Study of Risk and Adaptation

- Why do 30% of those abused/ neglected not go on to abuse/ neglect others?
  - They received emotional support from an alternate, non-abusive adult during childhood, or
  - Participated in a therapy experience of at least 6 months duration, or
  - Had an emotionally supportive and satisfying relationship with a mate as an adult

Brofenbrenner

Plates

Hospital Meeting

Marla and Theo

How did we get here?

Higher Risk Trauma and Attachment "Links"

- Trauma, Abuse and Neglect
- Disorganized Attachment
- Role Reversed Patterns (3-4)
- Other High Risk Patterns

Community Resources in La Crosse

- School Systems
  - PBIS systems
  - The Boys and Girls Club
  - The YMCA
- Gundersen
- Mayo
- Private Entities (various high quality outpatient clinics)
- La Crosse County
  - Outpatient Services
  - Mobile Crisis (608) 784-HELP
- 211

Recommended Books:

- ☐ Do They Have Bad Days In Heaven (sibling) Michelle Linn Gust
- ☐ My Son, My Son (family/support) Iris Bolton
- ☐ When Suicide Comes Home (father) Paul Cox
- ☐ Conquering the Beast Within (journal of depression)
- ☐ Tear Soup (Lovely analogy of grief journey)
- ☐ No Time to Say Goodbye (spouse) Carla Fine

Resources.. What Helps..What Hurts

NATIONAL

- Suicidology.org
- SPRC.org
- AFSP after a suicide toolkit
- Yellowribbon.org
- Mymichaelsplace.net
- Dougy.org
- Virtual Hope Box
- 1-800-273-TALK
- 741 741 Text Line
- NAMI.org (national alliance for mentally ill)
- DBSA (depression bipolar support alliance)

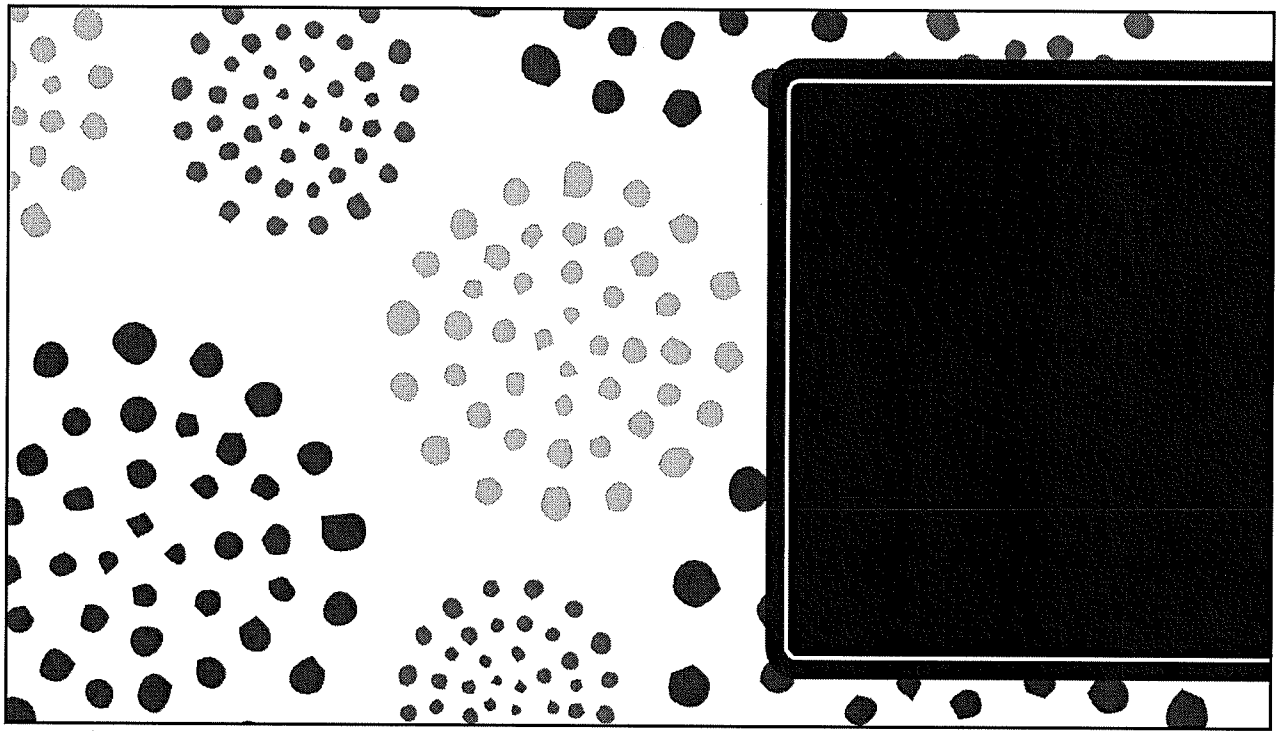
LOCAL

- Survivors of Suicide Support Group
- Family
- Faith Community
- CMH
- Counseling Agencies

trauma specialist (EMDR, Tapping)

- Children's grief centers
- 211

Barb Smith
989-781-5260
sosbarb@aol.com



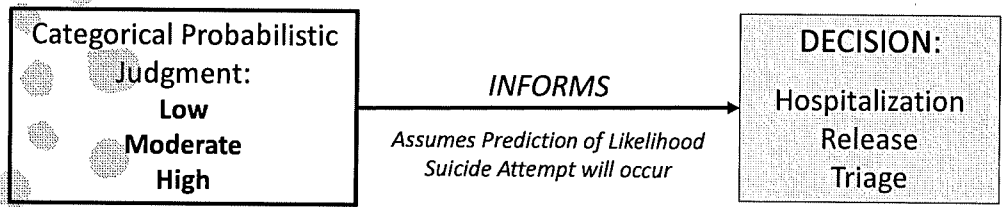
Why We Need New Models

- 32 yr old, Male Veteran, married, two young children. Deployed on 4 occasions; rescue missions, combat exposure, flight experience. Moved up ranks, leadership/training role. Family moves approx. every 4 yrs. Supportive, stay-at-home wife. Successful career, well liked, adequate but not a close social support network of friends and colleagues. No drug/alcohol problems. Family of origin is in tact but characterized as aloof, occasionally hostile, not engaged, high criticism of others, pressures for success, lacks warmth. No known history of maltreatment. Admits to struggling with depression, low self-esteem, self-doubt for majority of life – never sought treatment – fears consequences with military if know about MH concerns. Past few years increasing tension with wife; he feels disconnected, relationship is "exhausting," can't fully trust her (no reason), lack of emotional intimacy; perceives no truly close friends (features of paranoid/schizoid personality disorder). Wife increasingly distraught, pushing for therapy, begins talking about divorce. Client feeling pressured, believes divorce might be best, admits to wife he had frequent suicidal thoughts during deployments. Admits to some suicidal thoughts now. Agrees to seek marital counseling and at wife's encouragement has begun a self-help workbook for people with personality disorders / depression.

Standard of Care: Two Phase Process

Phase 1: **Suicide Risk Assessment (SRA)**

- Gather data about observable & reported risk and protective factors
- No guidance on how to organize, prioritize, synthesize data
  - *Clinical Intuition; Clinician Judgment*



Pisani et al., 2015; Silverman, 2014

Standard of Care: Two Phase Process

Phase 2: **Suicide Risk Formulation (SRF)**

- Process by which clinician forms a judgment about a patient's forseeable risk of suicidal behavior based on data from SRA
  - *Knowledge of how factors interact, exacerbate, enhance risk for client*
  - *Evaluate short-term risk and long term-risk*
  - *Placed in individualized context*
- Facilitate treatment planning and engage client in dialogue
- Therapeutic Risk Management
  - *Conceptualization shared with client (patient centered)*
  - *Supportive of treatment process*
  - *Maintains and grows therapeutic alliance*

Pisani et al., 2015; Silverman, 2014

New Risk Formulation Model

- **Purpose = Planning (not prediction!)**
  - Anchor each person's RISK within a context (research; individual hx)
- Incorporated Recent Advances in Field, SRF:
  - Anchored in the clinical context and patient population served
    - *need to describe risk in relative terms given population/setting work within*
  - Capture fluid nature of suicide risk within life of person
    - *How current risk compares to risk at previous times*
    - *How risk might change in response to future events*
  - Should lead directly to intervention strategies
    - *Data collected should produce risk management strategies*

Pisani et al., 2015; Silverman, 2014

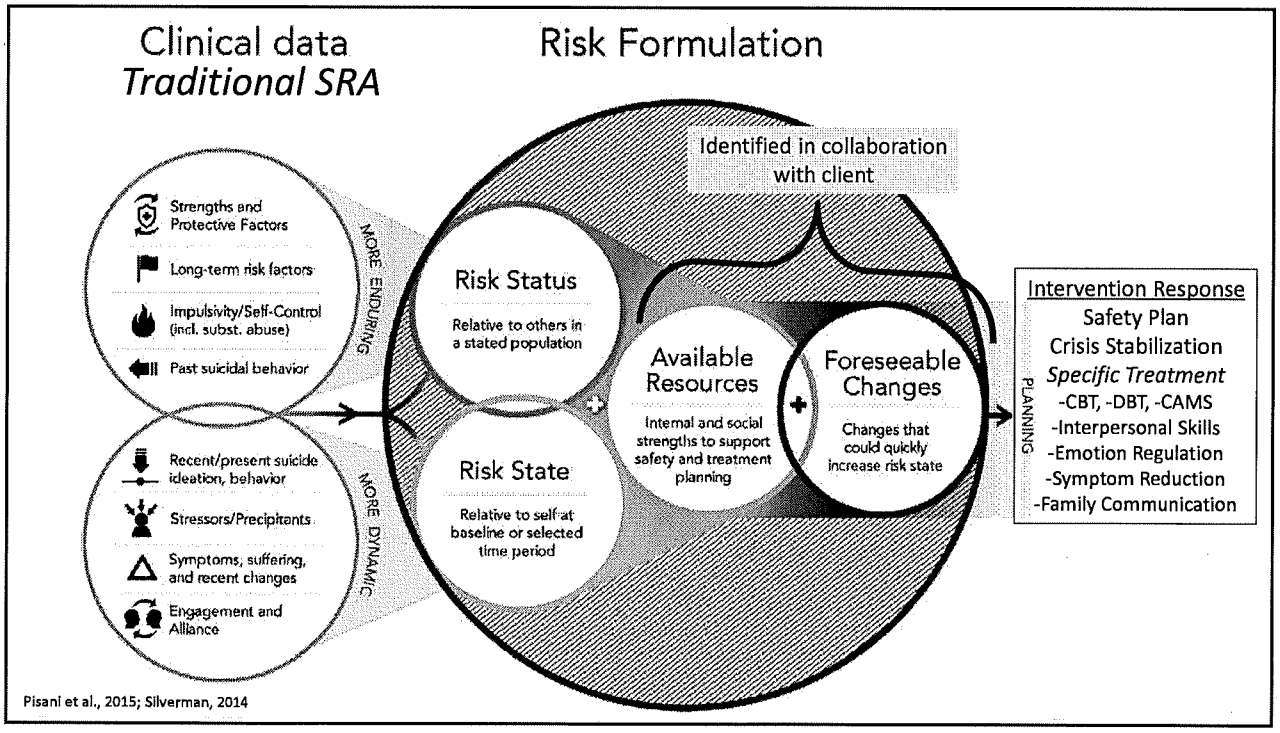
New Risk Formulation Model

- Prevention Oriented Risk Formulation
  - Goal of synthesis = promote communication & collaboration
  - ***Facilitates Prevention of suicide***
- Four Distinct Areas for Clinical Judgment = Synthesized into PLAN
  - **Risk Status** (risk relative to specified subpopulation)
  - **Risk State** (client's risk compared to baseline or other specified time)
  - **Available Resources** (to draw upon for crisis management)
  - **Foreseeable Changes** (things that may exacerbate risk)
    - *Establish contingency plan for these*

Pisani et al., 2015; Silverman, 2014

Example: Jasmine

- 16yr old, Hispanic-American female, bisexual (not disclosed), lives with biological mother, sister, step-sister, aunt, step-dad. No contact with bio father, neutral connection w/step-father. Mother immigrated to U.S. as young child. Living inner city, both caregivers employed but work long hours. Very traditional ethnic beliefs, strong Catholic beliefs. Client has hx of depression and anxiety with frequent cutting/NSSI; referred after suicide attempt. Progressing well in treatment, NSSI notably reduced but triggered by conflict with mother or peers; self-comparison with step-sibling. Client failing course, behavior problems increasing in school due to emergence of hallucinations, stopped medications. Mother learns of school issues, strong negative reaction but remains supportive. Begins increasing alcohol consumption & shares love triangle she is embedded within. Learns she will need to attend summer school; mother finds out about drinking/party client attended. Client NSSI increases; reports not as "effective" as used to be. Suicidal thoughts are increasing, very intense but manageable when voices are not being overly critical or commanding her to attempt suicide. Highly engaged in therapy, well connected and compliant; mother supportive; client sees aunt as support. Has close friends that she utilizes appropriately for support when needed. Has future goals.



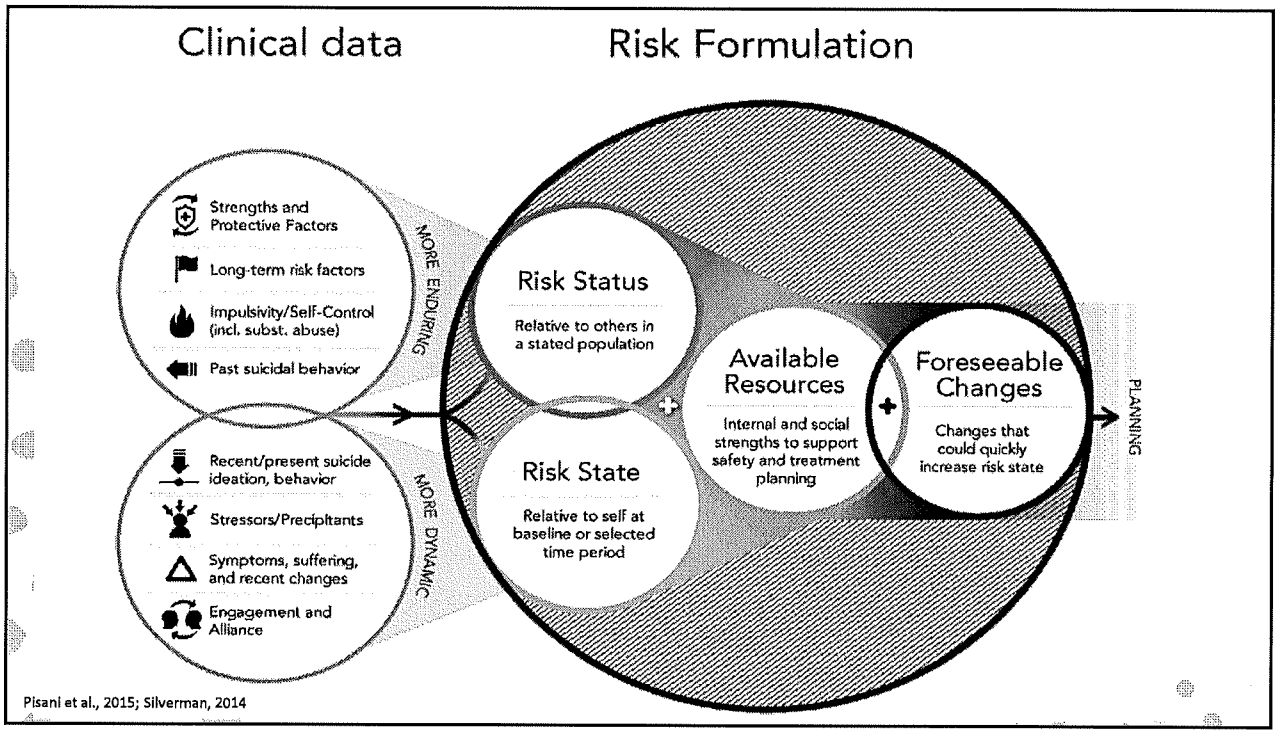
Pisani et al., 2015; Silverman, 2014

SRF → Documentation Guide

- Client is 16yo Hispanic female with long history of depression w/psychotic features and anxiety. She shows impulsivity through NSSI, occasional binge drinking, and has one previous suicide attempt that led to hospitalization. Current suicidal ideation is fleeting but of high intensity with no clear plan or intent to act. After 4 months of no NSSI, client has engaged in occasional acts over past 3 weeks reporting the NSSI is "less effective." In light of these factors, client's risk status is comparable to other adolescents treated at our outpatient mood disorders clinic. Given a recent increase in stressors including hallucinations, NSSI, and interpersonal conflict her current risk state is elevated compared to one month ago but remains lower than when admitted. Client is actively engaged in therapy, has a positive connection with her maternal aunt, and identifies peers as supportive. She continues to practice use of distress tolerance and interpersonal skills. Her suicide risk could increase pending significant arguments with her mother or a romantic relationship break-up and contingency plans for safety related to these events were discussed. Client's safety plan was reviewed and treatment will continue to address conflict resolution and distress tolerance skills along with ongoing CBT for depressive symptoms.

Your Try

- Greg is a 48 yo male with a long history of bipolar disorder and substance abuse. He was referred by his PCP, arriving reluctantly after endorsing "nearly every day" on the suicide-risk item of the routine depression screener. When asked about it, he stated "You never know what can happen when a guy is cleaning his gun, Doc." Greg has a history of inpatient hospitalizations due to erratic manic behavior & past suicide attempts (2) shortly after learning of his diagnosis & particularly bad episodes of depression, His most recent hospitalization due to mania was 6 months ago. He has been taking his medications and symptoms are well managed. Greg has been binge drinking more frequently in the past 3 months since discovering his wife and best friend in bed together. After confronting them, Greg drank heavily at a local bar, sped off in his car and struck a concrete wall, fracturing a hip and femur – injuries that continue to give him pain. Greg's wife strongly assures Greg that she has ended the relationship although Greg remains distrustful, moody, and angry. He binge drinks with coworkers after work at least 3 days each week, which intensifies his suicidal thoughts. Greg is increasingly agitated, irritable, and withdrawn from his wife and good friends despite stating that he is agreeable to attempts to repair their marital relationship. He admits his work is suffering to the point his boss made a comment, which has Greg concerned about possibly losing his job as a restructuring process is happening in the company. During an argument with his wife in the past week, Greg stated: "Maybe I should just shoot myself so you can screw Tom again without guilt." An avid hunter, Greg owns three guns. When asked about the comment, Greg emphatically states: "I say that when I am mad and overwhelmed, but I wouldn't do it." He also agreed to let a close friend keep his guns temporarily for safety. Greg is reluctant about therapy and not highly engaged, but is cooperative and states he is open to receiving "some assistance" to get his life "back on track."



Sharing Risk Formulation

- How many of you share your risk formulation with the client?
- Consistent with Concurrent/Collaborative Documentation Movement
  - **Benefits: Facilitates Understanding**
  - **Provides Insight & Sense of Autonomy/Control for Client**
  - **Therapeutic Impact**
- Client's report increased satisfaction and connection with Therapist
- Present Information in way families & clients can understand

Professional Reflection

- Reactions to new Suicide Risk Formulation Model
- What changes might you incorporate into your practice and/or share with colleagues

Questions?

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QPR Gatekeeper Training

- Welcome
- Introduction

Information about Depression

- Up to 25% of all Americans experience an episode of clinical depression during their lifetimes.
- Majority of depressed young adults don't receive treatment.
- Untreated depression is **the #1 cause of suicide**.
- Depression is **treatable**.

Symptoms of Depression

- Changes in sleep patterns (either more or less)
- Changes in appetite (either more or less)
- Decrease in self-esteem
- Increase in social isolation
- Decrease in concentration
- Decrease in energy and motivation
- Increase in alcohol and other substances

Symptoms of Depression (cont.)

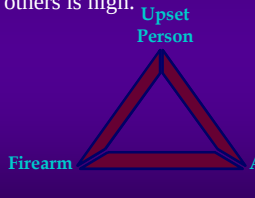
- Increase in irritability (especially in adolescents!)
- Increase in worrying and brooding
- Increase in tearfulness
- Less enjoyment of previously pleasurable activities
- Hopelessness; pessimistic outlook
- Thoughts of death, suicide, or self harm

Mental Illness and Suicide

- About 90% of all people who die by suicide are suffering from a major psychiatric illness:
  - Depression
  - Addiction
  - Anxiety
- These deaths are most often due to untreated or under-treated brain disorders.

The Deadly Triad

When these three are present, the risk of violence to self or others is high.



If you eliminate or resolve any side of the triangle, the immediate risk of violence to self or others is reduced!

Triggers or Last Straws

Loss of an idealized or important relationship
The "unacceptable wound"
Sudden sobriety and painful reality
Drug or alcohol relapse
Threat of loss
Health issues or concerns

Triggers or Last Straws (cont.)

Discharge phenomenon
Fear of becoming a burden to others
Lifting of depression
Contagion effect
Anything that "winks out the last ray of hope"

Increasing Hopelessness

- Hopelessness is the "final common pathway"
- The association between suicidality and hopelessness is stronger and more stable than the association of suicidality with depression and substance use disorders.

Epidemiology

- 3.7 male deaths by suicide for each female death.
- Populations at greatest risk
  - white males (especially elderly and those ages 40-59)
  - Native American (ages 10-39)
  - LGBT Youth
  - Veterans – 2 times as likely to die by suicide than not veterans

Considerations Regarding Methods/Means

- Suicide attempts by guns are **nearly always fatal** (versus 5% of the time by cutting and 23% by overdosing).
- To complete suicide by **hanging,** one does not have to be suspended.
- To complete suicide by **jumping,** one does not have to jump out of a multiple story building.

QPR Gatekeeper Training

- Suicide is Preventable!!

QPR

Ask A Question, Save A Life

©

QPR

Question, Persuade, Refer

©

QPR

- QPR is <u>not</u> intended to be a form of counseling or treatment.
- QPR <u>is</u> intended to offer hope through positive action.

©

QPR

Suicide Myths and Facts

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

©

QPR

Myths And Facts About Suicide

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction.
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question...

©

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Suicide Clues And Warning Signs

The more clues and signs observed, the greater the risk. Take all signs <u>seriously.</u>

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Direct Verbal Clues:

- "I've decided to kill myself."
- "I wish I were dead."
- "I'm going to commit suicide."
- "I'm going to end it all."
- "If (such and such) doesn't happen, I'll kill myself."

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- "I'm tired of life, I just can't go on."
- "My family would be better off without me."
- "Who cares if I'm dead anyway."
- "I just want out."
- "I won't be around much longer."
- "Pretty soon you won't have to worry about me."

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Behavioral Clues:

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

QPR

Situational Clues:

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others

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Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it

Q QUESTION

Less Direct Approach:

- "Have you been unhappy lately?
  Have you been very unhappy lately?
  Have you been so very unhappy lately that you've been thinking about ending your life?"

- "Do you ever wish you could go to sleep and never wake up?"

Q QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How Not to Ask the Question

"You're not suicidal, are you?"

P PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

P PERSUADE

Then Ask:

- Will you go with me to get help?"
- "Will you let me help you get help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

R REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.

For Effective QPR

- Say: "I want you to live," or "I'm on your side...we'll get through this."
- Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

For Effective QPR

- Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.
- Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR, YOU PLANT THE SEEDS OF HOPE. HOPE HELPS PREVENT SUICIDE.

Happiness

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

What Is Mental Health?

- What is mental health? Is mental health like physical health? Being average? Better than average? Being content with what you have? Striving to be improve?

What is Physical Health?

- Physical Health
  - 1) Optimal functioning of bodily systems
  - 2) Freedom from disease
  - 3) Energy, stress management
  - 4) Healthy lifestyle and environment
  - 5) Productive engagement with the world
  - 6) Physical joy

The Right Stuff

- The most intense study of what constitutes positive physical and mental health came in the early 1960's with the beginning of the Mercury Space Program.

The Right Stuff: The Seven Mercury Astronauts

- Exemplary work records
- Competent at loving (intact, happy, small-town families)
- Adventurous, but unusually few accidents, even before becoming pilots
- Could tolerate close interdependent association or extreme isolation

The Right Stuff

- They trusted others
- They did not complain under discomfort
- Emotions, positive and negative, were strongly experienced
- They were not introspective and seldom dwelled on their feelings, but could describe them if asked to
- Aware of the feelings of others

The Right Stuff

- They avoided interpersonal conflict
- Their group score on the neuroticism scale of the Maudsley Personality Inventory has been described as the lowest of any group reported in the literature. (Neuroticism is a personality trait characterized by instability of mood, anxiety, aggression, etc.)

Mental Health

- 1) Optimal functioning of the brain
  - Above average functioning – 91-100 on the old GAF scale
- 2) Freedom from disease
  - Mental illness, dementia
- 3) Energy, stress management
  - Resilience

Mental Health

- 4) Healthy lifestyle and environment
  - Challenge, meaning, connection
- 5) Productive engagement with the world
  - Social-emotional intelligence, maturity
- 6) Joy
  - Happiness

Promoting Brain Health

- Stop smoking: smoking doubles the risk of dementia. Stopping smoking in midlife cancels the risk. Smoking also impairs name and face recall.
- Avoid illicit drugs, head injury, toxins
- Stay socially active: reduces stress and is intellectually stimulating in ways that games and reading are not. (Negative engagement is harmful.)
- Meaningful activity may be especially protective.

Promoting Brain Health

- Exercise: moderately vigorous and regular (walking briskly 5-6 hours/week.) Exercise promotes cardiac health, good lung function, and an increase in neurotropins.
- Eat a Mediterranean style diet: grains, fruits, vegetables, non-saturated fats. Omega-3 fatty acids from fish may be important.
- Moderate alcohol consumption: why?

Promoting Brain Health

- Keep learning: intellectual enrichment stimulate the brain to make more connections and may have greater reserves of cognitive ability to sustain more neuronal loss without problems.
- Manage stress: mild stress results in neurogenesis. but severe chronic stress does not. Cortisol damages neurons.
- Get a good night's sleep: Sleep consolidates memories and reduces cortisol.

Healthy Lifestyle and Environment

- Connection: humans are social animals who are born to connect. It is very difficult to find any examples of people who are healthy physically or mentally who are not connected somehow to another human being.

Social Support and Life Expectancy

- Men and women without ties to others are 1.9 to 3 times more likely to die from ischemic heart disease, cerebral vascular disease, or cancer within a nine year period than individuals with more social contacts.
- The effect of social support on life expectancy appears to be as strong as the effects of obesity, cigarette smoking, hypertension, or level of physical activity.

Biological Research

- Happiness and unhappiness are not on a continuum. We seem to have a positive system and a negative system that operate separately, but can stifle each other. And in terms of evolutionary design, bad is stronger than good.

The Positive and Negative Systems

- Negative
  - Like Velcro
  - Very sensitive
  - Bitter 1:2,000,000
  - I HATE to lose
  - Triggered by poverty
  - 1 negative remark
  - Stronger reaction to negative language
  - Strong and damaging stress response
  - Harder to adapt to
- Positive
  - Like Teflon
  - Not sensitive
  - Sweetness 1:200
  - Winning is OK
  - Money has no effect
  - 5 positive remarks
  - Weaker response to positive language
  - Pleasure response not very physically active
  - Fast adaptation

Defining Happiness

- The Pleasurable Life: Pleasure and Enjoyment
- The Engaged Life: Feeling Good and Flow
- The Meaningful Life: Purpose

The Pleasurable Life

- The pleasurable life consists of experiencing as many pleasures as possible and learning to amplify and savor them.
- Pleasure may range from the basic to the very refined.
- The ability to experience pleasure seems to be very genetic (about 50%.) People who are very social tend to also experience a lot of this kind of happiness.
- Unfortunately, we tend to habituate/adapt very rapidly to pleasure.

Adaptation

- Soon after a major event, we return to normal so we can be motivated again. This is called "Adaptation." Our brains are not trying to make us happy. They are trying to regulate us. "Wanting" is structural. No amount of "getting" can fill it up.
- Our unimaginably successful consumer economy is based on this phenomenon.

US Citizens: "Necessities"

Item	1970	2000
Second car	20%	59%
Second TV	3%	45%
More than 1 telephone	2%	78%
Car air conditioning	11%	65%
Home air conditioning	22%	70%
Dishwasher	8%	44%

The Good Life

- The good life is a life devoted to developing and refining our capabilities. It is an investment in the present in order to improve the future. It involves purposeful engagement, positive self-regard, high quality relationships, and personal growth.
- Two different experiences contribute to the good life:
  - being in a good mood
  - the experience of "flow."
- This kind of happiness is usually what is referred to when writers talk about our happiness "set point." We may be born a cheerful person, or someone who easily becomes engages in "flow."
- Studies show that people who are happy most of the time also tend to be:
  - Optimistic
  - Appreciative
  - Social

The Meaningful Life

- The meaningful life arises when people both know their strengths and use them not in a self-focused way, but in the service of something "larger" than themselves. The boundary between self and other is permeable. It is, in many respects, the pursuit of virtue.

Generosity

- Increase in happiness by having a income increase from $20,000 to $80,000: 16%
- Increase in happiness from never volunteering to volunteering once a week: 16%.
- 2008 study: employees who gave more of their bonus money to charity reported greater happiness than those who gave less.

What makes for an overall satisfying life?

- After interviewing thousands of subjects, it appears that "pleasure" has only a marginal contribution to overall life satisfaction. "Flow" contributes much more strongly. "Meaning" has the largest contribution.
- A survey of 30,000 American households found that those who gave to charity were 43% more likely to say they were "very happy" than those who did not give.

Happiness Traps

- 1) Money
- 2) Family
- 3) Not taking into account impact bias and adaptation – nothing will be as good as we hope
- 4) Not taking into account our psychological immune system – nothing will be as bad as we are afraid of
- 5) Trying to maximize our options
- 6) The self-esteem movement
- 7) The comparing mind

Can Money Buy Happiness?

- The historical research says money can buy happiness and it already has.
- Throughout history, most people have been racked by illness, the desperate hunger of their children, continual drudgery, and the threat of violent animals.
- However, data suggests that once you have enough, more money does not make much difference.

Money and Happiness

- People who make $50,000/yr are a lot happier than those who make $10,000. But people who make $5 million/year aren't that much happier than those who make $100,000/yr.
- The data says that if you are poor, a little money can buy a lot of happiness. But if you are rich, a lot of money can only buy you a little more happiness.

What Would Make You Happy?

- Most people believe that having children would make them happy. Most parents would say that some of their best moments of happiness involved their children, but on a day-to-day level, people aren't particularly happy when they're interacting with their children. Women looking after their children are significantly less happy than when they're watching TV. (Children are hard work!)

Some Myths About Choice

- 1) You will be happier and perform better if you make your own choices: "Be true to yourself."
- This may be true in American culture today, but it is not necessarily true for everyone.

Myths About Choice

- 2) The more choices you have, the more likely you are to get what you want, and the happier you will be.
- Americans have become the most skilled people in the world at spotting differences between similar items, in order to pick out the "best." In fact, studies show that when people have ten or more options, they tend to make bad choices.

Are Options Good For Us?

- The more choices we have, the more likely we are to regret our choice. It is easy to idealize the choice we did not take. We experience an "escalation of expectations."

Comparing Mind

- We underestimate our "comparing" mind. We are always looking at those around us and comparing our circumstances to theirs. What makes people happy is not wealth, for instance, but relative wealth. Most of us would feel happier making $50,000/yr in a job where the average salary is $40,000, than making $60,000/yr in a job where the average is $70,000.

The Biggest Trap

- The biggest trap is thinking of happiness as a permanent state. Happiness is a momentary experience. You can't *be happy* all the time. No one would like you. Happiness shouldn't be a goal.
- But being mentally healthy is a reasonable goal. What do we know about how to do that?

The Goal: Not Just Happy, but Mentally Healthy

- 1) Optimal functioning of the brain
  - Above average functioning – 91-100 on the old GAF scale
- 2) Freedom from disease
  - Mental illness, dementia
- 3) Energy, stress management
  - Resilience

Mental Health

- 4) Healthy lifestyle and environment
  - Challenge, meaning, connection
- 5) Productive engagement with the world
  - Social-emotional intelligence, maturity
- 6) Joy
  - Happiness

Increasing Pleasure: Single Task

- You can't fully pay attention to multiple things. (People who multitask are not doing anything as well as people who single task. In fact, the posterior lateral prefrontal cortex delays one task while you are working on another. We do one thing at a time.)

Increasing Pleasure: Set a Happiness Trap for Yourself

- Trying to feel happier feels forced and may backfire. Instead of trying to boost your happiness in the moment, maximize your odds of feeling good by planning activities that you know make you happy. In short, plan to do those things that make you feel good. Like taking a walk...The natural world makes most humans happy. Almost everyone enjoys listening to music.

Enjoy the Past

- You can also savor things that happened in the past. Participants in one study who spent ten minutes, twice a day reminiscing about a pleasurable event felt happier during the week than those who spent the time thinking about current issues in their lives. *But don't overanalyze*, which interferes with the effect. Looking at pictures, listening to music, re-reading letters all were helpful.

Hold on to Good Experiences for 20 Seconds

- Let yourself be happy when you have a good moment! Aversive events get stored more quickly in memory, and are more rapidly recalled. Positive events are stored through the standard memory systems and need to be held in conscious awareness for 10-20 seconds for them to be coded and held onto.
- Help positive events become positive experiences by paying extra attention to them. Hold them in consciousness longer. Savor them so they sink in.

A Little More About This…

- Negative events have more salience for us than positive events and are coded faster. If the typical "moment" in a human's consciousness is ~3 seconds, it is easy to imagine that as we construct the "remembering self" (our story), we will preferentially be using negative events. Could this be the source of all the negative self-talk that most of us have?

Increasing Pleasure

- The brain is wired to things that are novel. Adaptation means that frequent small pleasant events have a bigger impact than occasional large events.
- Slow down: time affluence predicts happiness better than monetary affluence. Eliminate some of the less enjoyable ways you spend your time. Taking a break improves focus.

Increasing Pleasure

- Get enough sleep. People who are sleep deprived are more negative and more emotionally vulnerable to stresses.
- A big part of pleasure is looking forward to something. Savor that.

Maximizers vs. Satisficers

- Maximizers are like perfectionists – they need to be assured that every purchase, every decision, is the very best that could be made. They are never satisfied.
- Satisficers have criteria and standards, but will be satisfied when those criteria are met, rather than wondering if there is something better is around the corner.

Maximizers vs. Satisficers

- In a 2008 study conducted by U Minn at a mall, having to make more choices interfered with participants ability to pay attention and solve arithmetic problems.
- In a Columbia/Swarthmore study comparing maximizers and satisficers during a job hunt, the maximizers found jobs that paid 20% more than the satisficers, but had more bad experiences during the job hunt, and ended up less happy with their jobs.

Satisficers are Happier than Maximizers

- Work on being a "Satisficer" rather than a "Maximizer."
  - Restrict your options (two stores, e.g.)
  - Realize when a choice has met your core requirements
  - Consciously limit the time spent on wondering about other options that you have missed.

Expanding the Social World

- People with 5+ friends outside of immediate family are happier than those with fewer friends. Work toward spending more time socializing.
- Can pets increase your happiness?

Human-Companion Animal Interaction

- Most pet owners view their pets as enhancing the quality of family life by minimizing tension between family members and enhancing the owner's compassion for living things. At least one study found that dog owners were as emotionally as close to their dogs as to their closest family member. 33% were actually closer than to any other human family member.
- One study found post-MI survival rates higher for pet owners than non-pet owners. Another study of 5,700 people showed male pet owners had significantly lower systolic blood pressure, triglyceride and cholesterol levels.

Money Can Buy Happiness!

- (if you give it away)

Evaluating Aid Sites

- Charitynavigator.org
- Givewell.net
- Thelifeyoucansave.com
- Donorschoose.org

Do your Optimism and Gratitude Exercises

- Pessimists who spent one week writing down experiences when they felt good about themselves and others were happier than controls 6 months later.
- In one 10 week study, keeping a gratitude journal of 5 things they were thankful for, once a week, increased happiness levels, reduced doctors visits, and helped people exercise (!) in participants.

Happiness as a byproduct of living your life is a great thing. But happiness as a goal is a recipe for disaster.

Barry Schwartz, Swarthmore College

"It is only a slight exaggeration to say that happiness is the experience of spending time with people you love and who love you."

- Daniel Kahneman, Nobel Laureate

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Men and Depression

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Disclosure

- Dr. Mays is not on any drug advisory boards, paid for doing drug research, or otherwise employed, funded, or consciously influenced by the pharmaceutical industry or any other corporate entity.
- No off label uses of medications will be discussed unless mentioned in the handout and by the presenter.
- No funny business.

"I am now the most miserable man living. If what I feel were equally distributed to the whole human family, there would not be one cheerful face on earth.

Whether I shall ever be better, I cannot tell: I awfully forebode I shall not. To remain as I am is impossible. I must die or be better, it appears to me."

Robert Wilson, fellow legislator of Lincoln's, 1836

"He (Lincoln) told me that although he appeared to enjoy life rapturously, still he was the victim of a terrible melancholy. He sought company, and indulged in fun and hilarity without restraint. Still when by himself, he told me that he was so overcome with mental depression, that he never dare carry a knife in his pocket. As long as I was intimately acquainted with him, he never carried a pocket knife."

Depression

- Depression is a commonly experienced mood and a syndrome. A clinical depression is distinguished from a depressed mood by the intensity and pervasiveness of its symptoms. Depressed people are usually not able to relate to others and may be able to express only a limited range of emotions. They are frequently obsessively focused on themselves and how they are feeling moment to moment. In a primary care setting the following complaints may identify depression: sleep disturbance, fatigue, somatic complaints.

An Alternative Description to DSM

- The present criteria for "Major" Depressive Disorder was the result of a compromise between scientists and analysts in writing the DSM-III. Originally, major and minor types of depression were proposed, but since the analysts worked with "minor" depression, and were afraid they would not be reimbursed for treatment if it was called minor, all the criteria were subsumed into Major Depression. What has been lost is the phenomenology of depression.

The Spectrum of Major Depression
(Ghaemi 2012)

- Melancholic
- Neurotic
- Mixed
- Pure

Melancholic Depression

- Severe and generally unassociated with anxiety
- Psychomotor retardation
- Marked anhedonia
- No reactivity – patients are not labile and are unresponsive to psychological stressors. (Bad events don't make them feel worse because they can't feel any worse.)
- Episodic, not chronic, but lengthy
- More common in bipolar depression than unipolar
- High suicide risk
- Tricyclic antidepressants, Electroconvulsive therapy

Neurotic Depression

- Mix of mild depression and mild anxiety
- High degree of sensitivity to psychosocial stressors
- Chronic, not episodic, although they may be easily pushed into a major depressive episode by stress
- Probably more temperament than disease
- Does not respond to antidepressants any more than to placebos

Mixed Depression

- Major depression with 1-3 manic symptoms
- Core features: irritability, agitation, mood lability
- More common in bipolar disorder, but frequently present in major depressive disorder
- Recent research indicates that more people with mood disorders have mixed symptoms than purely depressive or manic (at least 40% of the total)
- Antipsychotics are more effective than antidepressants

Pure Depression

- Some mood reactivity, some interests, somewhat functional (not melancholic)
- No mania, little or no anxiety (not mixed)
- Episodic (not neurotic)
- The new antidepressants may be the most effective in this group.

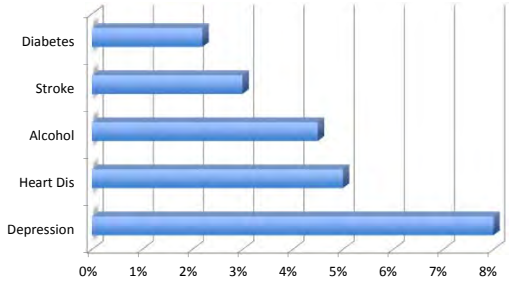
Demographics

- Depression is the fourth leading cause of disease burden worldwide, 1st in the United States. Lifetime prevalence may be 7-12% of men, 20-25% of women. High risk groups include Native Americans (19.17%) and Caucasians (14.58%). Asians are at lowest risk (8.77%).
- There is high comorbidity with anxiety disorders (36%) and personality disorder (37%).
- Mortality is high. 46% wish to die. 9% report a suicide attempt. Risk of suicide death is 20x higher – 15% lifetime risk. 30-70% of suicides have a depressive disorder.

Impairment

- 44% of depressed people have some sort of functional work impairment, 11% are unable to work altogether. In 2020, major depression will be second only to heart disease in the amount of disability suffered.
- Cardiac clients have 4x greater risk of depression and depression a month after a heart attack is the best predictor of MI in next year - the risk is the same as being a smoker – 5x more likely to die than healthy peers.

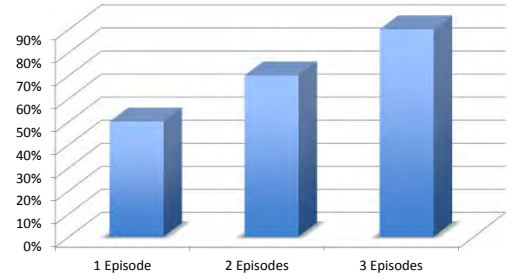
Causes of Disability



Natural History

- Depression is a lifelong illness, likely to relapse within a few months after the first episode.
- Average age of onset is late 20-40 years old. Symptoms develop over days or weeks.
- Prodromal symptoms include anxiety, panic, phobias, low grade depression.
- Episodes last from 6 to 24 months.
- There is strong evidence that sub-syndromal continuation of symptoms represent a continuation of the illness, and will lead to relapse.

Risk of Recurrence of Depression (*DSM-IV-TR*)



Depression and Clinical Practice

- In clinical practice, the diagnosis of “depression” is used across a wide variety of clinical presentations of depressed mood. It can encompass major depressive disorder, depression in bipolar disorder, dysthymia, reactive depression, an overall sense of dysphoria or pessimism, bereavement, and the depression found in personality disorders, particularly borderline. It may be a sign of many different disorders, similar to “fever” or “inflammation” in medical practice.

Symptoms

- Affective
  - Depressed mood
- Vegetative
  - Weight loss or gain
  - Insomnia or hypersomnia (insomnia has a bidirectional relationship to depression – a cause and an effect)
  - Decreased sex drive
- Behavioral
  - Psychomotor retardation or agitation
  - Fatigue
  - Diminished interest or pleasure in most activities

Symptoms

- Cognitive
  - Feelings of worthlessness or guilt
  - Diminished ability to think and concentrate
  - Poor frustration tolerance
  - Negative distortions
  - Affective agnosia and apraxia
- Impulse Control
  - Recurrent thoughts of suicide, homicide, or death
- Somatic
  - Headaches, stomach aches, muscle tension
- Chronic Painful Physical Conditions

Symptoms

- Clients with depression have difficulties with interpersonal relationships, largely related to problems with emotional perception and executive function. They misidentify happy facial expressions as sad, for instance.
- There is evidence of mood state dependent learning - clients don't remember ever feeling good, increasing the risk of suicide. These memories can be retrieved with proper prompting and cueing.

Comorbidities

- Social anxiety disorder is a major risk factor
- Comorbid personality disorder confers worse prognosis and treatment response
- Obesity and metabolic syndrome – bidirectional
- Coronary artery disease
- 65% increase in risk for diabetes
- Secretion and production of proinflammatory enzymes

Gender Issues

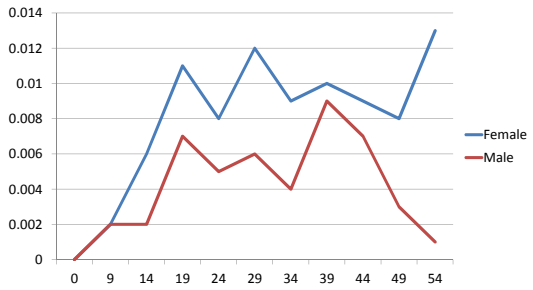
Depression is "a fixed melancholy."
Emily Dickinson

Depression is "a rage spread thin."
George Santayana

Gender Issues

- Women are twice as likely to be depressed as men (1/5 vs. 1/10). The gender difference begins at 10 and continues until the mid 50's. Social and hormonal influences contribute to making adolescence a difficult transition for girls. Estrogen may boost levels of cortisol and inhibit GABA.
- Menopause is strongly associated with new onset depression.
- College education, being in the first marriage, working outside the home lowers risk. Single mothers have 2x the depression risk as mothers with partners.

Hazard Rate for Depression



Women

- More likely to describe themselves as sad or depressed with more symptoms and higher degree of distress
- More "reverse" symptoms (hypersomnia, increased appetite, somatization)
- Friendship networks are larger, which buffers and creates stress.
- Marriage is protective for men, but not for women.

Gender

- Women are more likely to seek healthcare for depression, in part, because women enter the healthcare system more frequently than men due to seeking birth control and/or pregnancy. If men are more likely to attribute their depression to finances, etc., they are less likely to view the healthcare system as the place for help.

Why the Gender Difference?

- Genes: Heredity may account for ~40% of the risk of major depression. Certain genetic mutations that are associated with the development of severe depression occur only in women.
- Hormones: The gender difference begins at puberty. Hormonal changes that accompany menstruation bring on mood changes. Some women are vulnerable to depression after childbirth or menopause. But it has not been proven that hormonal changes significantly alter mood in large groups of women.

Why the Gender Difference?

- Stress: Women are more likely than men to say that they are under stress. Some studies indicate that women are more likely to become depressed after a stressful event. Women are more likely to experience certain kinds of stress, such as child sexual abuse, sexual assault, and domestic violence. Women are more likely than men to be caregivers. Women are also more likely to live in poverty than men, and be single parents.
- Exercise: Women are less likely to get exercise and be in poor physical health than men.

Gender

Am J Psychiatry, April 2014

- In a large, opposite sex twin study, the following risk factors were defined for each gender:
  - Women: deficiencies in caring relationships and interpersonal loss
    - Neuroticism, divorce, absence of parental warmth and social supports, lack of marital satisfaction
  - Men: failure to achieve expected goals and lowered self-worth
    - Childhood sexual abuse, conduct disorder, drug abuse, financial, occupational, legal stress

Men

- Testosterone may make boys more susceptible to seizures (and possibly autism) due to the increase in GABA, but may protect them from depression later on.
- SSRI's may work better in the presence of estrogen.
- They are less likely to seek help and 4x more likely to die of suicide than women, although they attempt suicide 3x less often.

Symptoms in Men

- Men are more likely
  - to lose weight when depressed
  - to show OCD symptoms rather than simply anxiety
  - to abuse substances
  - to show anger and irritability
  - to increase risk taking

Suicide Epidemiologic Risk Factors

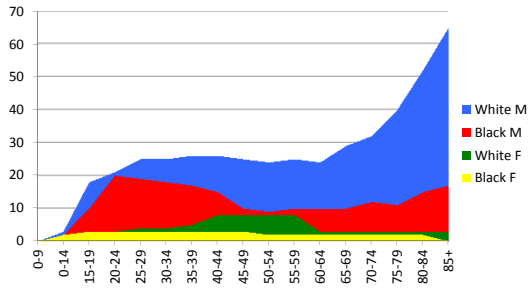
- Gender, Age, and Race
- Marital Status
- Family History
- Mental Illness History
- Newness in Treatment Program
- Time of Year
- Rural vs. Urban
- Natural/Unnatural Disasters
- The Media

NESARC Data (n=43,093) Suicide Findings

- Among depressed people:
  - Highest suicide attempts – Hispanic, Latino, younger age, low income
  - Comorbidity with any anxiety disorder, personality disorder, substance abuse
  - In men, depression + dependent personality disorder (75% will make a suicide attempt)
  - In women, antisocial personality disorder
  - Most predictive symptom: feeling worthless

Gender, Race, and Age

Natl Center Health Statistics, 2006



Gender

- Gender differences in suicide deaths have complicated attempts to understand the epidemiology of suicide. Women have low suicide mortality, but a higher incidence of the two most significant risk factors – depression and suicide attempts.
- Risk factors of increasing age, single marital status, physical illness, stressful life events, unemployment, and low socioeconomic status apply only to men.

Gender

- The reason for this gender difference is not known. It is suggested that in men, higher rates of substance abuse, violence, and greater social expectation that a real man will "succeed" in a suicide attempt contribute to men using more lethal means than women.
- In contrast, women tend to exhibit more help-seeking behavior, have more social connectivity, have more "permission" to make non-fatal attempts, and may assume more responsibility for the feelings of children and family members

The Problem

- Suicide rates have not decreased in the last decade, or in the last 110 years. Compare this with progress made in other areas of public health: breast and skin cancer, HIV, automobile accidents, etc. where we have seen a decrease in death rates from 40-80%.

The Problem

- Preventing suicide is not easy. The base rate of suicide is low creating a number of statistical and research problems. Our current approach of using epidemiologic risk factors has no clinical utility. Even the highest odds ratio is not informative at an individual level. (The best predictor is a previous suicide attempt, but 60% of suicides occur on the first attempt.) Furthermore, decades of research have failed to identify any new predictors. We have no biological markers.

The Problem

- People who are at risk of suicide do not seek help. 80% of people who die of suicide have seen a provider prior to their attempt, but did not identify themselves as suicidal, largely because they think they do not need help.
- Treatment is often not optimal. Community treatments (gatekeeper training, school programs) are not coordinated with medical interventions (treatment of mental illness, follow-up.)

The Problem

- Cardiovascular disease and cancer research have studies that include hundreds of thousands of patients. We need that kind of power to determine effective treatments.
- In order to study short-term risk, real time monitoring may provide helpful ideas. Less than 1% of risk factor studies look at the week before the suicide.

The Problem Christensen JAMA May 2016

- Mobile phones
- Certain phrases and use of personal pronouns in blogs\digital footprints on Twitter – machines can learn to detect disturbing tweets.
- Data mining may help uncover risk factors
- Facial and voice characteristics
- Social media can facilitate help seeking and peer support. Suicide prevention apps and websites can deliver assessment and information.

Mariano Sigman, PhD

Shifts in Our Thinking About Depression

- From neurotransmitters to neuroplasticity
  - Neurogenesis, dendritic pathology…
- From chemical imbalance to neuro-inflammation
- From serotonin and norepinephrine to glutamate
- From oral to parental administration
- From delayed efficacy to immediate efficacy
- From pharmacotherapy to neuromodulation

"Network Model"

- Hypothesis: the problem is not so much with neurotransmitter inadequacy, but rather with networks of cells that are dysfunctional.
- A 2012 meta-analysis of brain scan studies found high baseline activation in the pulvinar, a large nucleus in the thalamus. This structure is part of a fast, unconscious processing stream for priming behavior in the face of a threat, as well as for focusing emotional attention and awareness.

Network Theory

- The amygdala, dorsal anterior cingulate cortex, and insula are all overactive to negative stimuli.
- These data are consistent with the hypothesis that negative cognitive biases play a crucial role in the onset and maintenance of major depression.
- These sensory inputs fail to propagate to the dorsolateral prefrontal cortex, which would ordinarily allow the individual to appraise and correct this negativity.

Bottom Line

- Current imaging research indicates a bias of attention to negative emotional stimuli and a lack of recognition of positive emotional and rewarding stimuli.
- There is increased activity supporting emotion processing and reduced activity in neural systems supporting regulation of emotions (dorsolateral prefrontal cortex.)

Free Depression Outcome Scale

- Patient Health Questionnaire-9 (PHQ-9) www.depression-primarycare.org/forms/phq_9/

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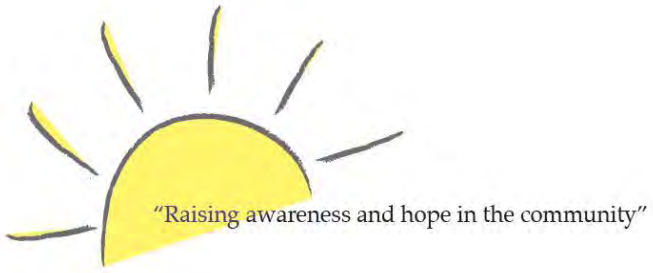
La Crosse Area

Suicide Prevention Initiative



Directory of Mental Health Resources for Suicide Prevention

June 2016

Great Rivers 2-1-1™
Get Connected. Get Answers.

The La Crosse Area Suicide Prevention Initiative and Great Rivers 2-1-1 compiled this guide to help people who are struggling with suicide issues in the La Crosse area.

Table of Contents

Information in this guide is provided by Great Rivers 2-1-1. La Crosse County information is included. For information on resources in other counties **contact** *Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 (or visit the Web site at www.greatrivers211.org).*

MENTAL HEALTH RESOURCES

24-HOUR MENTAL HEALTH CRISIS INTERVENTION RESOURCES

Great Rivers 2-1-1

24-hour 3-Digit Crisis Line 2-1-1

24-hour Toll Free Crisis Line ..... (800) 362-8255

Internet Web Site: www.greatrivers211.org

Area Served includes: Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin; Fillmore, Houston, and Winona Counties in Minnesota; Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa

La Crosse County Human Services Department ..... (608) 784-4357 (784-HELP)

Area Served includes: La Crosse County

Note: *Mental health crisis intervention services for La Crosse county; call Great Rivers 2-1-1 for information about other counties*

SUICIDE HOTLINES

Great Rivers 2-1-1

24-hour 3-Digit Crisis Line 2-1-1

24-hour Toll Free Crisis Line ..... (800) 362-8255

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Area Served includes: Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin; Fillmore, Houston, and Winona Counties in Minnesota; Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa

Boys Town National Hotline ..... (800) 448-3000

Internet Web Site: www.boystown.org

- *Provides a short-term crisis hotline for children and families experiencing difficulties*

Alternate Web Site for Teens: www.yourlifeyourvoice.org **HELP VIA ONLINE CHAT AND TEXTING IS AVAILABLE ON THIS WEB SITE**

TEXT (available form 4 pm – 1 am daily).....20121

Area Served: Nationwide

HOPELINE – Texting Crisis Line 741741

Area Served includes: All of Wisconsin

Note: *Texting line only; no phone calls*

Kristin Brooks Hope Center – National Hopeline Network ..... (800) 442-4673

Internet Web Site: www.hopeline.com

- *Provides telephone crisis counseling and suicide intervention*

Area Served: Nationwide

National Suicide Prevention Lifeline..... (800) 273-8255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides a suicide prevention service available to individuals in emotional crisis who are seeking help*

Area Served: Nationwide

The Trevor Project Lifeline ..... (866) 488-7386

Internet Web Site: www.thetrevorproject.org **HELP VIA ONLINE CHAT ON THIS WEB SITE**

Texting Available 3 pm – 7 pm Thursday and Friday.....Text the word Trevor to 1-202-304-1200

- *Suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth*

Area Served: Nationwide

You Matter..... (800) 273-8255

Internet Web Site: www.youmatter.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides help and support for teenagers, college students, and young adults*

Area Served: Nationwide

Your Life Iowa – Youth Suicide Prevention Line..... (855) 581-8111

Internet Web Site: www.yourlifeiowa.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

Texting Available 2 pm – 10 pm Daily..... (855) 895-8398

- *Provides telephone crisis counseling and suicide intervention for youth*

Area Served: Iowa

Veterans Crisis Line.....(800) 273-8255 then press 1,.... or send a text message to 838255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides suicide prevention services to veterans in emotional crisis*

Area Served: Nationwide

SUICIDE-RELATED WEBSITES

American Association of Suicidology	www.suicidology.org
American Foundation of Suicide Prevention	afsp.org
JED Foundation (suicide prevention among college students)	www.jedfoundation.org
Mental Health America of Wisconsin	www.mhawisconsin.org

National Hopeline Network	www.hopeline.com
Prevent Suicide Wisconsin	www.preventsuicidewi.org
Suicide Awareness and Voices of Education	www.save.org
Suicide Prevention Resource Center	www.sprc.org
Wisconsin Department of Public Instruction	http://sspw.dpi.wi.gov/sspw_suicideprev
Wisconsin Injury Prevention Program	http://www.dhs.wisconsin.gov/health/injuryprevention/index.htm

SUICIDE RESOURCES FOR SPECIAL POPULATIONS

(Serves Nationwide unless noted)

YOUTH

Boys Town National Hotline..... (800) 448-3000

Internet Web Site: www.boystown.org

- *Provides a short-term crisis hotline for children and families experiencing difficulties*

Alternate Web Site for Teens: www.yourlifeyourvoice.org HELP VIA ONLINE CHAT AND TEXTING IS AVAILABLE ON THIS WEB SITE

Text VOICE to 20121

National Graduate Student Crisis Line..... (877) 472-3457

Internet Web Site: www.gradresources.org/crisisline

- *Provides immediate help for graduate students in crisis*

The Trevor Project Lifeline ..... (866) 488-7386

Internet Web Site: www.thetrevorproject.org **HELP VIA ONLINE CHAT ON THIS WEB SITE**

Texting Available 3 pm – 7 pm Thursday and Friday.....Text the word Trevor to 1-202-304-1200

- *Suicide prevention helpline for lesbian, gay, bisexual, transgender and questioning (LGBTQ) youth*

You Matter..... (800) 273-8255

Internet Web Site: www.youmatter.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides help and support for teenagers, college students, and young adults*

Youth America Hotline..... (877) 968-8454

Internet Web Site: http://www.yourlifecounts.org/

- *Provides a teen-to-teen peer counseling hotline*

VETERANS

River Valley Integrated Health Center – Mental Health Clinic..... (800) 827-8662, ext. 63301

- *Outpatient mental health services*

Area Served: Allamakee, Clayton, Fayette, Howard, and Winneshiek Counties in Iowa; Fillmore, Houston, and Winona Counties in Minnesota; Buffalo, Chippewa, Crawford, Dunn, Eau Claire, Grant, Jackson, La Crosse, Monroe, Pepin, Richland, Trempealeau, and Vernon Counties in Wisconsin

Veterans Affairs Medical Center – Tomah..... (800) 872-8662

Internet Web Site: www.tomah.va.gov

- *Inpatient and outpatient services*
- *Medical care, mental health care, substance abuse treatment, dental care, and socialization and support programs*

Area Served: Adams, Clark, Crawford, Jackson, Juneau, La Crosse, Lincoln, Marathon, Monroe, Portage, Price, Taylor, Trempealeau, Vernon, Waushara, and Wood Counties in Wisconsin; Houston County in Minnesota

Veterans Crisis Line..... (800) 273-8255 then press 1,..... or send a text message to 838255

Internet Web Site: www.suicidepreventionlifeline.org **HELP VIA ONLINE CHAT IS AVAILABLE ON THIS WEB SITE**

- *Provides a suicide prevention service available to veterans in emotional crisis who are seeking help*

Vet2Vet..... (877) 838-2838

Internet Web Site: www.vet2vetusa.org/

- *Provides a veterans' peer support line*

MILITARY FAMILIES

Military OneSource..... (800) 342-9647

Internet Web Site: www.militaryonesource.mil

- *Helps military personnel and deployed civilians and their families to find help with every aspect of military life*

SPANISH SPEAKING

Spanish Speaking Hotline - Kristin Brooks Hope Center – National Hopeline Network..... (800) 784-2432

Internet Web Site: www.hopeline.com

- *Provides telephone crisis counseling and suicide intervention for people who speak Spanish*

OTHER SPECIAL POPULATIONS

For information about resources for other special populations (individuals with disabilities, senior citizens, Native Americans, members of the Hmong Community, or other special populations) contact Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 or visit the Web site at www.greatrivers211.org

SUPPORT GROUPS

Survivors of Suicide Support Group (La Crosse)..... (608) 633-3135

- *For families and friends who have lost a loved one to suicide*

Support Group for Families of People with Mental Illness (La Crosse)..... (608) 779-1554

- *For families and friends of the chronically mentally ill and other interested persons*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – La Crosse*

Depressed Anonymous (La Crosse)..... (608) 791-5295 or (608) 794-4393

- *For individuals who deal with depression*

Support Group for Persons with Mental Illness (Viroqua)..... (608) 637-8143

- *For people with chronic mental illness, their families and friends*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – Vernon County*

NAMI Support Groups (Winona)..... (507) 459-3475 or (507) 494-0905

- *For adults with mental illness including depression, schizophrenia, bipolar disorder, anxiety disorders, and other mental health problems; also offers a support group for families and friends*
- *Sponsored by NAMI (National Alliance for the Mentally Ill) – Winona County*

Mental Health Related Support Groups for Veterans..... (800) 827-8662, ext. 63301

- *Various groups sponsored by River Valley Integrated Health Center*

Mental Health Related Support Groups for Veterans..... (608) 782-4403

- *Various groups sponsored by La Crosse Vet Center*

Wellness Recovery Support Groups (La Crosse)..... (608) 785-9615

- *For anyone who has a mental illness, as well as family and friends*
- *Sponsored by Independent Living Resources*

MENTAL HEALTH DROP-IN CENTERS

Coulee Council on Addictions Resource Center..... (608) 784-3939

921 West Avenue, La Crosse

- *Provides a chemical-free social/recreational atmosphere for substance abusers in recovery*

Area Served: La Crosse, Monroe, Trempealeau and Vernon Counties in Wisconsin; Houston County in Minnesota

Family and Children's Center – Viroqua Office – The Other Door..... (608) 637-7052

1321 North Main Street, Viroqua

- *Provides a chemical-free social/recreational atmosphere for positive networking opportunities*

Area Served: Vernon County

Hiawatha Valley Mental Health Center Peer Support Network..... (507) 454-4341

252 West Wabasha, Winona

- *Provides a drop center with social and recreational activities*

Area Served: Houston, Wabasha, and Winona Counties in Minnesota and Buffalo and La Crosse Counties in Wisconsin

RAVE Mental Health Drop-In Center (Recovery Avenue)..... (608) 785-9615

1806 State Street, La Crosse

- *Provides social and recreational activities; staffed by mental health consumers*

Area Served: La Crosse County

COUNSELING AND RELATED RESOURCES

There are a number of resources for people who are seeking assistance with life concerns as well as for people who have ongoing mental health concerns. These include:

- **Area counseling agencies providing individual or family counseling regarding a variety of concerns,**
- **Agencies providing ongoing mental health and psychiatric management services**
- **Department of Human Services in each county**

Some of these services are available for free and many agencies offer their services based on a sliding fee scale or can bill Medical Assistance or other insurances. Great Rivers 2-1-1 can provide information about and referrals to these and other supportive services. ***Contact Great Rivers 2-1-1 by dialing 2-1-1 or (800) 362-8255 or visit the Web site at www.greatrivers211.org . The Great Rivers 2-1-1 line is available 24 hours/day, 7 days/week including all holidays.***

MEDICAL ASSISTANCE PROGRAMS

There are government programs which provide health care coverage ***(often including mental health care)*** *for low income people. With the implementation of the national Affordable Care Act, many options are changing. For updated information see:*

www.healthcare.gov

Wisconsin:

BadgerCare Plus *provides coverage for pregnant women, children, individuals and families meeting eligibility criteria. For information or to apply contact:*

Maternal and Child Health Hotline..... (800) 722-2295

Or

Visit the Web site at www.badgercareplus.org. This Web site provides information and also allows people to enter the ACCESS Web site where they can check to see if they are eligible for BadgerCare Plus or other assistance programs and apply for any of these programs directly online.

Minnesota:

Medical Assistance *provides coverage for children and families, pregnant women, senior citizens, and people with disabilities meeting eligibility criteria.* ***MNSure*** *provides coverage for children and families, pregnant women, and adults without children meeting eligibility criteria. In addition there may be other resources to provide some limited medical care coverage assistance for certain populations, including some non-citizens. For information about any of these programs contact the local county or:*

Minnesota Department of Human Services..... (855) 366-7873

Minnesota Department of Human Services Web site..... www.applymn.dhs.mn.gov

Iowa:

Various ***Medical Assistance*** programs *and* ***HAWK-I*** *provide coverage for eligible populations in Iowa. For information about any of these programs contact the local county or:*

Iowa Department of Human Services..... (800) 972-2017

Online Application for State of Iowa Services (OASIS)..... www.oasis.ia.gov

ADDICTIONS HELP

Many health care providers and counseling agencies offer help for addictions. For more information about specific services contact:

Great Rivers 2-1-1..... 2-1-1 or (800) 362-8255

Internet Web Site: www.greatrivers211.org

ALCOHOL AND OTHER DRUGS

Alcoholics Anonymous (AA) La Crosse Area Intergroup..... (866) 491-8004

Internet Web Site: www.aalacrosse.org

- *Twelve Step support groups for people with alcoholism*

Alcoholics Anonymous (national hotline)..... (212) 870-3400

Internet Web Site: www.aa.org

- *Twelve Step support groups for people with alcoholism*

Al-Anon Family Groups (national hotline)..... (888) 425-2666

Internet Web Site: www.al-anon.alateen.org

- *Twelve Step support groups for families and friends of people with alcoholism*

Cocaine Anonymous World Service Office..... (800) 347-8998

Internet Web Site: www.ca.org

- *Provides confidential assistance, information and referral, education and services to people of all ages dealing with cocaine and other mind-altering substance3s*

Coulee Council on Addictions (La Crosse)..... (608) 784-4177

Internet Web Site: www.couleecouncil.org

- *Provides confidential assistance, information and referral, education and services to people of all ages dealing with substance abuse and other addictions*

Area Served: La Crosse, Monroe, Trempealeau and Vernon Counties in Wisconsin; Houston County in Minnesota

Family Empowerment Network Information Line..... (800) 462-5254

Internet Web Site: www.pregnancyandalcohol.org

- *Toll free information number for women and the providers who work with women of childbearing age who are looking for information about women and alcohol, alcohol and pregnancy, and related issues*

La Crosse County Human Services Department – Integrated Support & Recovery Services...(608) 784-4357

Area Served Includes: La Crosse County

Note: *Substance abuse services vary by county; call Great Rivers 2-1-1 for information about other counties.*

Narcotics Anonymous (national hotline)..... (818) 773-9999

Internet Web Site: www.na.org

- *Twelve Step support groups for people with addictions*

Substance Abuse and Mental Health Services Administration (SAMHSA)..... (800) 662-4357

Internet Web Site: *www.samhsa.gov*

- *Helpline and searchable database of substance abuse treatment options*

GAMBLING

Gamblers Anonymous (national hotline)..... (855) 222-5542

Internet Web Site: www.gamblersanonymous.org

- *Support groups for people with gambling addictions*

Gamblers Anonymous – Gam-Anon La Crosse Area..... (608) 784-4177

Internet Web Site: www.couleecouncil.org/supportgroups.html

- *Support groups for people with gambling addictions*

Gam-Anon (national hotline)..... (718) 352-1671

Internet Web Site: www.gam-anon.org

- *Information and support for families and friends of people with gambling addictions*

Iowa Gambling Treatment Program..... (800) 238-7633

Internet Web Site: www.1800betsoff.org

Minnesota Problem Gambling Helpline..... (800) 333-4673

Internet Web Site: www.getgamblinghelp.com

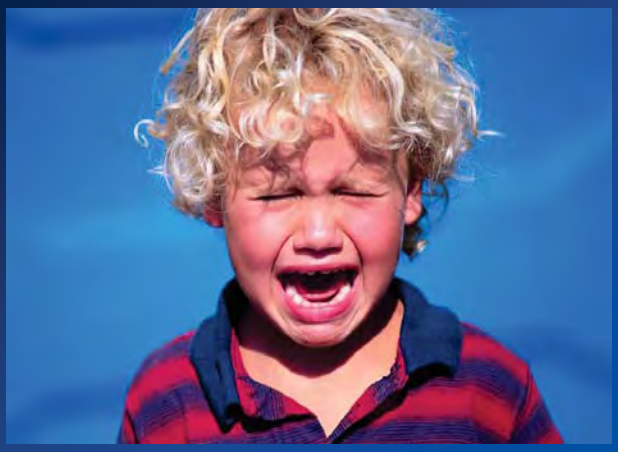
National Council on Problem Gambling..... (800) 522-4700

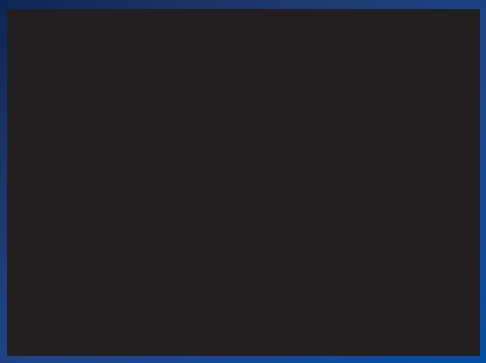
Internet Web Site: www.ncpgambling.org

Wisconsin Council on Problem Gambling..... (800) 426-2535

Internet Web Site: www.wi-problemgamblers.org

De-Escalation of Children Crisis





Introduction

- Why are some crises with this (my) child so seemingly out of control?
- Why don't traditional and/ or well intentioned approaches seem to help?
- What does help?

Important Concepts

Trauma

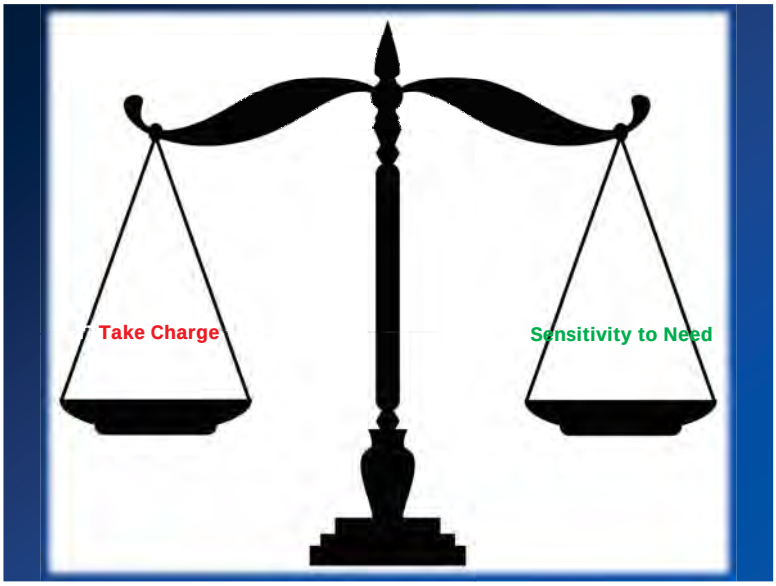
Attachment

Emotional Regulation and Emotional Development

Re-Enactment

Being the Hands

Focusing on Needs



How did that go?

Important Mindsets or "Mantras" to help Us

- **Behavior Management versus Sensitivity to Need (COS)**
- **What's wrong with you versus What happened to you (CPP)**
- **"I'm showing you rather than telling you I have a need"**
- **The Iceberg Metaphor (TF-CBT)**
- **"The Electric Fence"**

Fighting our Internal Battle

- Finding something that you truly value or "love" about someone and fusing with it
- Continually connecting yourself to that place/ space

Respect Should be earned, not demanded.

"I'm In"

- Going in to situations with children and adolescents telling yourself "I want to get this right"

"We do not believe in ourselves until someone reveals that deep inside us something is valuable, worth listening to, worthy of our trust, sacred to our touch. Once we believe in ourselves we can risk curiosity, wonder, spontaneous delight or any experience that reveals the human spirit." E. E. Cummings

What's wrong with you vs. What Happened to you

Banana Peels

2 hour Dysregulation

Behavior and Emotion Regulation Across Development

Re-enactment/ Old patterns

What's wrong with you versus what happened (or is happening) to you?

Did she fail in that interaction?

Was she ever not in charge?

Was she insensitive?

Did she look afraid of him?

Did she seem like she wanted to help him?

Looking at Health 1st

Attachment Theory

Other Evidence Based Models

The importance of natural "attunement"

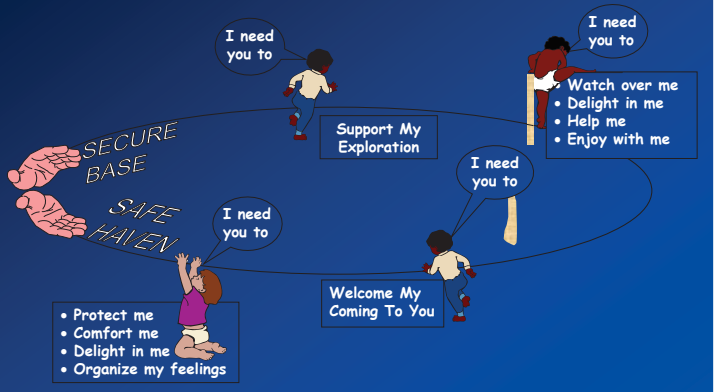
Motivational Interviewing (with everyone)

- Getting yourself out of the way
- Accurate Empathy – how do you know its accurate?
- People have within them enormous untapped potential

Circle of Security

Parent Attending to the Child's Needs

© Cooper, Hoffman, Marvin, & Powell, 1999

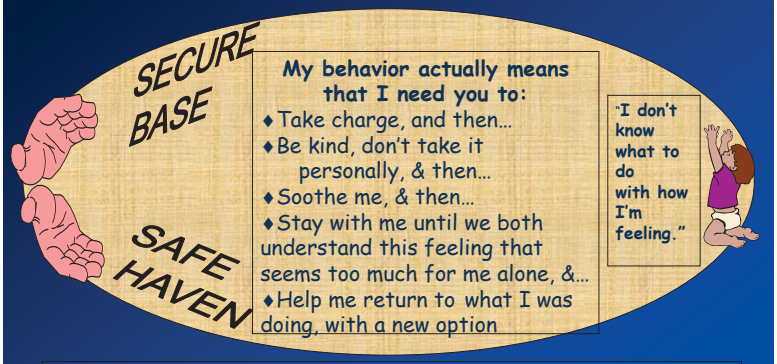


"I'm struggling – and I'm being disrespectful"

Crisis: Divide and Conquer

- **Emotional "allergies" or tensions**
- **Sometimes the interpersonal interaction collectively creates this**

Mom & Dad, when I get difficult (frustrated, demanding, upset, out of control):



CIRCLE OF REPAIR

Helping My Child Trust that Our Safe & Secure Relationship Will (Almost) Always Set Things Right

"She Needs Her Mother"

- Crisis call – with responder, adolescent, mother, local hospital social worker
- Mom from Eastern Block country

Little Miss Sunshine clip

Miscommunication

"If a community values its children, it must cherish the parents" – John Bowlby, MD, Father of Attachment Theory

My Meds (26 year old adult)

"No one understands what you've been through" (22 year old adult)

"From a 45 to a 4" (15 year old boy)

Attunement

The Minnesota Study of Risk and Adaptation

- Why do 30% of those abused/ neglected not go on to abuse/ neglect others?
  - They received emotional support from an alternate, non-abusive adult during childhood, or
  - Participated in a therapy experience of at least 6 months duration, or
  - Had an emotionally supportive and satisfying relationship with a mate as an adult

Brofenbrenner

Plates

Hospital Meeting

Marla and Theo

How did we get here?

Higher Risk Trauma and Attachment "Links"

- Trauma, Abuse and Neglect
- Disorganized Attachment
- Role Reversed Patterns (3-4)
- Other High Risk Patterns

Community Resources in La Crosse

- School Systems
  - PBIS systems
  - The Boys and Girls Club
  - The YMCA
- Gundersen
- Mayo
- Private Entities (various high quality outpatient clinics)
- La Crosse County
  - Outpatient Services
  - Mobile Crisis (608) 784-HELP
- 211

Resources.. What Helps..What Hurts

NATIONAL

- Suicidology.org
- SPRC.org
- AFSP after a suicide toolkit
- Yellowribbon.org
- Mymichaelsplace.net
- Dougy.org
- Virtual Hope Box
- 1-800-273-TALK
- 741 741 Text Line
- NAMI.org (national alliance for mentally ill)
- DBSA (depression bipolar support alliance)

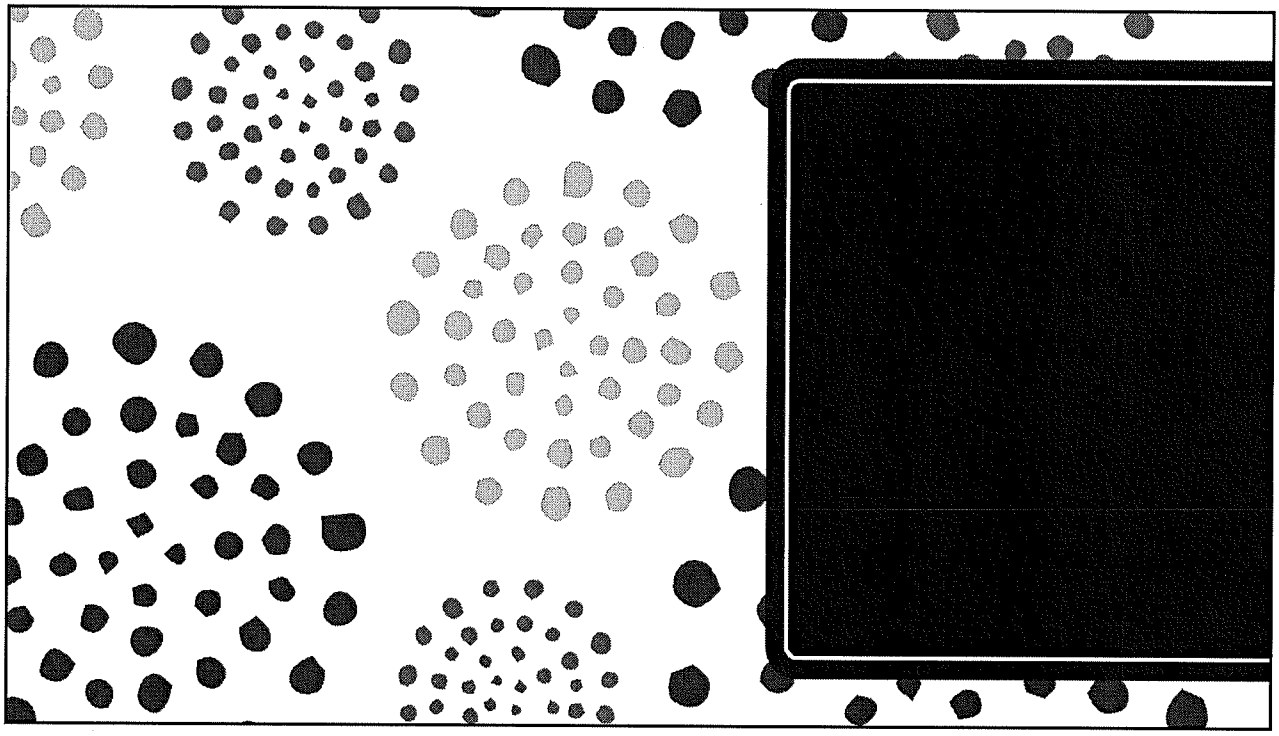
LOCAL

- Survivors of Suicide Support Group
- Family
- Faith Community
- CMH
- Counseling Agencies

trauma specialist (EMDR, Tapping)

- Children's grief centers
- 211

Barb Smith
989-781-5260
sosbarb@aol.com



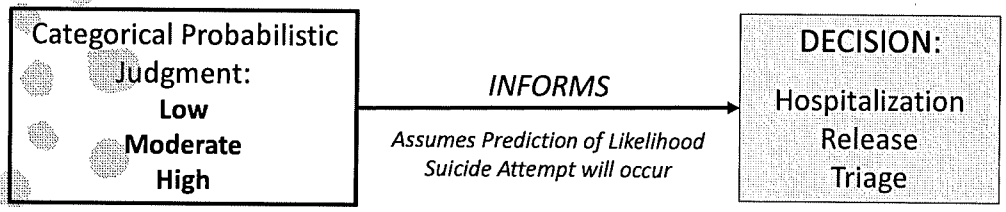
Why We Need New Models

- 32 yr old, Male Veteran, married, two young children. Deployed on 4 occasions; rescue missions, combat exposure, flight experience. Moved up ranks, leadership/training role. Family moves approx. every 4 yrs. Supportive, stay-at-home wife. Successful career, well liked, adequate but not a close social support network of friends and colleagues. No drug/alcohol problems. Family of origin is in tact but characterized as aloof, occasionally hostile, not engaged, high criticism of others, pressures for success, lacks warmth. No known history of maltreatment. Admits to struggling with depression, low self-esteem, self-doubt for majority of life – never sought treatment – fears consequences with military if know about MH concerns. Past few years increasing tension with wife; he feels disconnected, relationship is "exhausting," can't fully trust her (no reason), lack of emotional intimacy; perceives no truly close friends (features of paranoid/schizoid personality disorder). Wife increasingly distraught, pushing for therapy, begins talking about divorce. Client feeling pressured, believes divorce might be best, admits to wife he had frequent suicidal thoughts during deployments. Admits to some suicidal thoughts now. Agrees to seek marital counseling and at wife's encouragement has begun a self-help workbook for people with personality disorders / depression.

Standard of Care: Two Phase Process

Phase 1: **Suicide Risk Assessment (SRA)**

- Gather data about observable & reported risk and protective factors
- No guidance on how to organize, prioritize, synthesize data
  - *Clinical Intuition; Clinician Judgment*



Pisani et al., 2015; Silverman, 2014

Standard of Care: Two Phase Process

Phase 2: **Suicide Risk Formulation (SRF)**

- Process by which clinician forms a judgment about a patient's forseeable risk of suicidal behavior based on data from SRA
  - *Knowledge of how factors interact, exacerbate, enhance risk for client*
  - *Evaluate short-term risk and long term-risk*
  - *Placed in individualized context*
- Facilitate treatment planning and engage client in dialogue
- Therapeutic Risk Management
  - *Conceptualization shared with client (patient centered)*
  - *Supportive of treatment process*
  - *Maintains and grows therapeutic alliance*

Pisani et al., 2015; Silverman, 2014

New Risk Formulation Model

- **Purpose = Planning (not prediction!)**
  - Anchor each person's RISK within a context (research; individual hx)
- Incorporated Recent Advances in Field, SRF:
  - Anchored in the clinical context and patient population served
    - *need to describe risk in relative terms given population/setting work within*
  - Capture fluid nature of suicide risk within life of person
    - *How current risk compares to risk at previous times*
    - *How risk might change in response to future events*
  - Should lead directly to intervention strategies
    - *Data collected should produce risk management strategies*

Pisani et al., 2015; Silverman, 2014

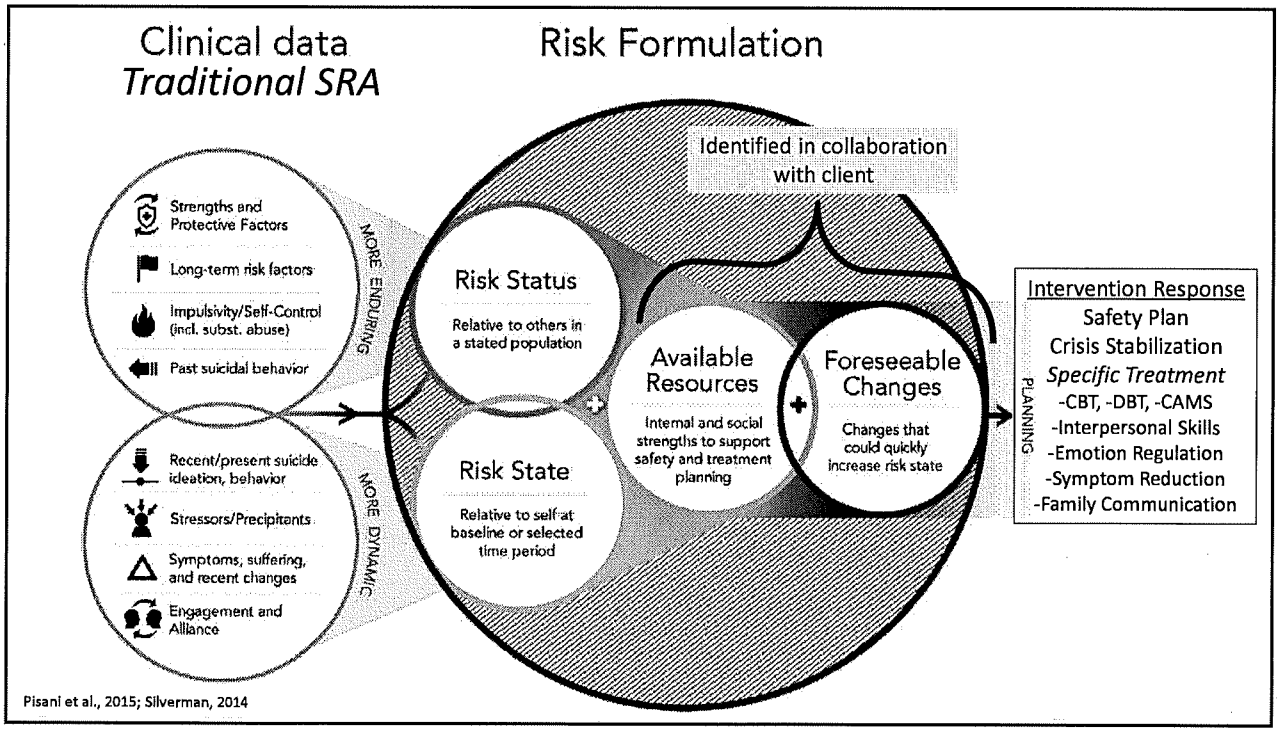
New Risk Formulation Model

- Prevention Oriented Risk Formulation
  - Goal of synthesis = promote communication & collaboration
  - ***Facilitates Prevention of suicide***
- Four Distinct Areas for Clinical Judgment = Synthesized into PLAN
  - **Risk Status** (risk relative to specified subpopulation)
  - **Risk State** (client's risk compared to baseline or other specified time)
  - **Available Resources** (to draw upon for crisis management)
  - **Foreseeable Changes** (things that may exacerbate risk)
    - *Establish contingency plan for these*

Pisani et al., 2015; Silverman, 2014

Example: Jasmine

- 16yr old, Hispanic-American female, bisexual (not disclosed), lives with biological mother, sister, step-sister, aunt, step-dad. No contact with bio father, neutral connection w/step-father. Mother immigrated to U.S. as young child. Living inner city, both caregivers employed but work long hours. Very traditional ethnic beliefs, strong Catholic beliefs. Client has hx of depression and anxiety with frequent cutting/NSSI; referred after suicide attempt. Progressing well in treatment, NSSI notably reduced but triggered by conflict with mother or peers; self-comparison with step-sibling. Client failing course, behavior problems increasing in school due to emergence of hallucinations, stopped medications. Mother learns of school issues, strong negative reaction but remains supportive. Begins increasing alcohol consumption & shares love triangle she is embedded within. Learns she will need to attend summer school; mother finds out about drinking/party client attended. Client NSSI increases; reports not as "effective" as used to be. Suicidal thoughts are increasing, very intense but manageable when voices are not being overly critical or commanding her to attempt suicide. Highly engaged in therapy, well connected and compliant; mother supportive; client sees aunt as support. Has close friends that she utilizes appropriately for support when needed. Has future goals.



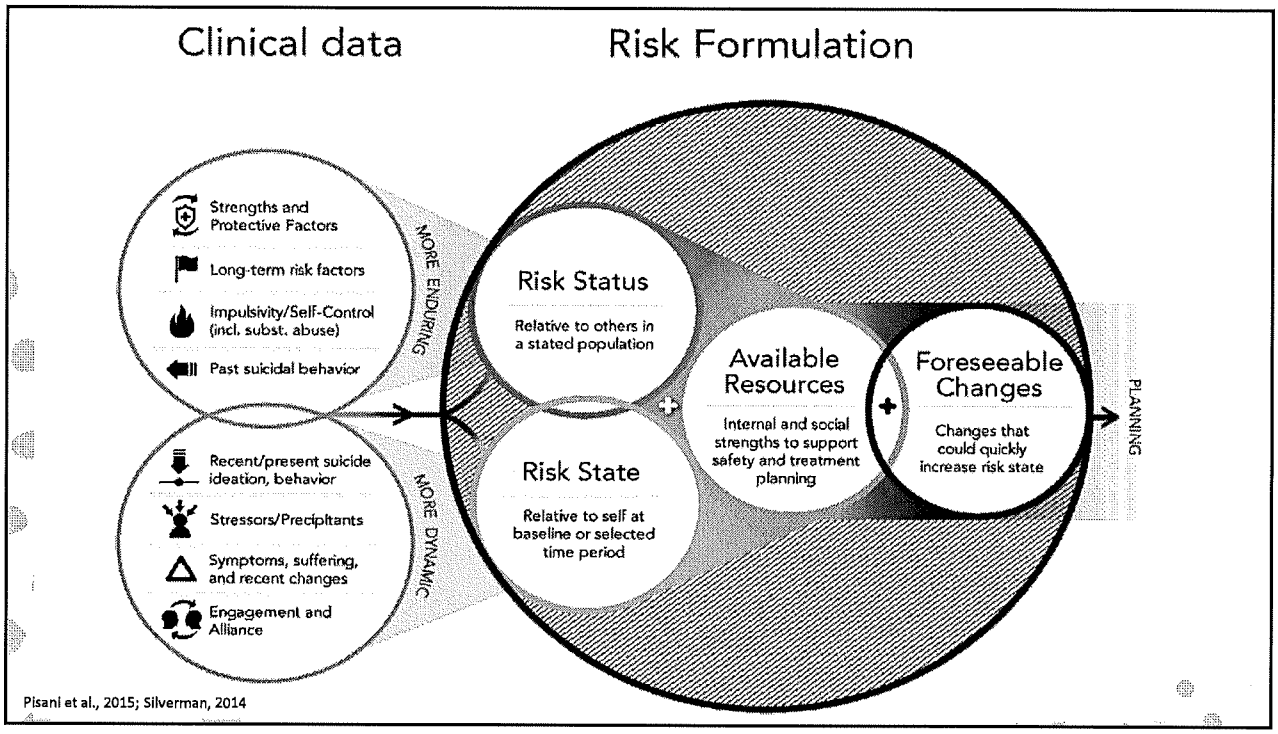
Pisani et al., 2015; Silverman, 2014

SRF → Documentation Guide

- Client is 16yo Hispanic female with long history of depression w/psychotic features and anxiety. She shows impulsivity through NSSI, occasional binge drinking, and has one previous suicide attempt that led to hospitalization. Current suicidal ideation is fleeting but of high intensity with no clear plan or intent to act. After 4 months of no NSSI, client has engaged in occasional acts over past 3 weeks reporting the NSSI is "less effective." In light of these factors, client's risk status is comparable to other adolescents treated at our outpatient mood disorders clinic. Given a recent increase in stressors including hallucinations, NSSI, and interpersonal conflict her current risk state is elevated compared to one month ago but remains lower than when admitted. Client is actively engaged in therapy, has a positive connection with her maternal aunt, and identifies peers as supportive. She continues to practice use of distress tolerance and interpersonal skills. Her suicide risk could increase pending significant arguments with her mother or a romantic relationship break-up and contingency plans for safety related to these events were discussed. Client's safety plan was reviewed and treatment will continue to address conflict resolution and distress tolerance skills along with ongoing CBT for depressive symptoms.

Your Try

- Greg is a 48 yo male with a long history of bipolar disorder and substance abuse. He was referred by his PCP, arriving reluctantly after endorsing "nearly every day" on the suicide-risk item of the routine depression screener. When asked about it, he stated "You never know what can happen when a guy is cleaning his gun, Doc." Greg has a history of inpatient hospitalizations due to erratic manic behavior & past suicide attempts (2) shortly after learning of his diagnosis & particularly bad episodes of depression, His most recent hospitalization due to mania was 6 months ago. He has been taking his medications and symptoms are well managed. Greg has been binge drinking more frequently in the past 3 months since discovering his wife and best friend in bed together. After confronting them, Greg drank heavily at a local bar, sped off in his car and struck a concrete wall, fracturing a hip and femur – injuries that continue to give him pain. Greg's wife strongly assures Greg that she has ended the relationship although Greg remains distrustful, moody, and angry. He binge drinks with coworkers after work at least 3 days each week, which intensifies his suicidal thoughts. Greg is increasingly agitated, irritable, and withdrawn from his wife and good friends despite stating that he is agreeable to attempts to repair their marital relationship. He admits his work is suffering to the point his boss made a comment, which has Greg concerned about possibly losing his job as a restructuring process is happening in the company. During an argument with his wife in the past week, Greg stated: "Maybe I should just shoot myself so you can screw Tom again without guilt." An avid hunter, Greg owns three guns. When asked about the comment, Greg emphatically states: "I say that when I am mad and overwhelmed, but I wouldn't do it." He also agreed to let a close friend keep his guns temporarily for safety. Greg is reluctant about therapy and not highly engaged, but is cooperative and states he is open to receiving "some assistance" to get his life "back on track."



Sharing Risk Formulation

- How many of you share your risk formulation with the client?
- Consistent with Concurrent/Collaborative Documentation Movement
  - **Benefits: Facilitates Understanding**
  - **Provides Insight & Sense of Autonomy/Control for Client**
  - **Therapeutic Impact**
- Client's report increased satisfaction and connection with Therapist
- Present Information in way families & clients can understand

Professional Reflection

- Reactions to new Suicide Risk Formulation Model
- What changes might you incorporate into your practice and/or share with colleagues

Questions?

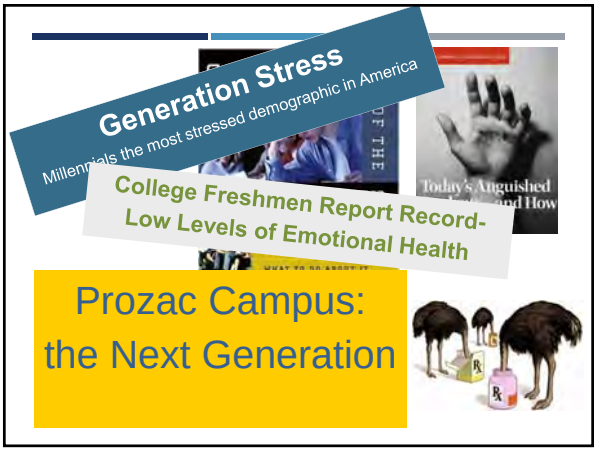
muehlejj@uwec.edu

THE ROLE OF RESILIENCE IN SUICIDE PREVENTION: WORKING WITH COLLEGE STUDENTS & OTHER EMERGING ADULTS

DR. GRETCHEN REINDERS
DIRECTOR, UWL COUNSELING & TESTING CENTER

LEARNING OBJECTIVES

1. Learn about trends specific to college student and emerging adult mental health.
2. Review of clinical assessment measures and treatment interventions specific to resilience.
3. Identify strategies for building resilience and learn how to apply these strategies for suicide prevention work with college students and emerging adults.



HOW THIS NARRATIVE IMPACTS EMERGING ADULTS

- First, let's define emerging adults
  - Not a new concept
  - The developmental period "from the late teens through the twenties, with a focus on ages 18-25."
  - Distinct identity development, different from adolescence or young adulthood, especially for individuals in industrialized countries.
  - Future is yet to be decided.
- What does it mean to reach "adulthood"?
  1) Responsibility for one's self
  2) Making independent decisions
  3) Financial independence

SO, HOW DOES THIS NARRATIVE IMPACT EMERGING ADULTS?

- Impact on educators who are teaching emerging adults:
  - Concern that students will become depressed or hostile with lower grades
  - Intolerance for the students' distress and/or assuming that they simply cannot cope when the students have very real and valid concerns
- Impact on employers of emerging adults:
  - Belief that they are ill-prepared for the "real world" or work
  - Over-emphasis on generation gap rather than creative methods of having multiple generations working alongside one another
- Impact on emerging adults themselves:
  - Individual's belief that they cannot tolerate distress, cannot problem-solve, cannot survive adverse situations
  - Seeking immediate help for perceived crises that could likely be solved on their own
  - Not seeking help because they do not get a quick answer or because they think the helping professional sees them as incapable

MERITS OF THIS NARRATIVE?

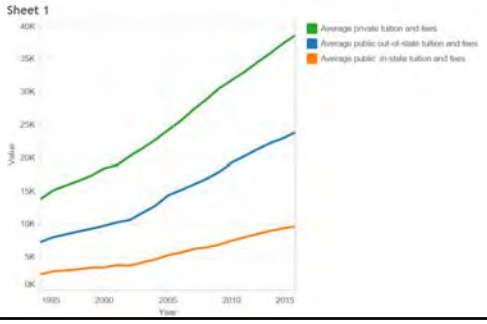
Are today's emerging adults really that different than those in the 70's, 80's, 90's?

- Consider the changing demographics of students
- Parental involvement
- Cost
- Achievement gap
- Global, national, and local events that shape worldview
- Stigma reduction, willingness to seek help
- Some things are consistent, others are different…

HELICOPTER AND SNOW PLOW PARENTING

Message sent to young people: you are not capable of making good decisions, of taking care of yourself

COST OF COLLEGE



SOCIAL MEDIA

MENTAL HEALTH TRENDS OF COLLEGE STUDENTS

- Today about 13 percent of college students enter into college having been diagnosed with a mental health condition.
- Research conducted by the National Institute of Mental Health shows that half of all lifetime cases of mental illness begin by age 14; three-fourths by age 24.
- Students are more likely to be referred and more willing to seek help
- Students who use campus counseling resources while at college are more likely to stay in school than students who do not use these services.

BY THE NUMBERS

Presenting Concern of CTC clients	%
Stress/Stress management	63%
Anxiety/fears/worries	60%
Depression/sadness/mood swings	60%
Problems related to school	45%
Low self-esteem/confidence	37%
Sleep difficulties	26%
Friends/roommates/dating concerns	26%
Eating behavior/body image	19%
Shyness/social discomfort	17%
Suicidal thoughts/urges	11%

NCHA data, specific to UWL respondents	*Any time within the last 12 months*
Felt so depressed that it was difficult to function	30%
Felt overwhelming anxiety	56%
Seriously considered suicide	6.5%
Intentionally cut, burned, bruised, or otherwise injured yourself	5.8%
Felt overwhelmed by all you had to do	91%

WHAT IS RESILIENCE?

"Resilience is the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of stress… It means "bouncing back" from difficult experiences (American Psychological Association)

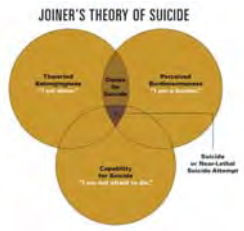
Resilience is not a trait that people either have or do not have. It involves behaviors, thoughts and actions that can be learned and developed in anyone.

RESILIENCE IN ADOLESCENCE AND EMERGING ADULTS

- *Protective factors* have often been proposed promoting/enhancing resilience, and typically fall into three categories:
  - *Individual*
    - coping skills, problem-solving skills, intelligence, internal locus of control ("I can shape my own life"), sense of purpose and goals, self-esteem, social competence and interpersonal communication
  - *Family*
    - secure attachment, direct guidance with encouragement; learning what NOT to do
  - *External/community*
    - caring non-parent adults (teachers, counselors, coaches, ministers, neighbors); positive peer relationships

HOW DOES RESILIENCE RELATE TO SUICIDALITY?

- How do you see these as related concepts?
- Consider Joiner's Interpersonal Theory of Suicide as one example:



HOW WE MIGHT ASSESS RESILIENCE

- Clinicians
- Educators
- Friends and Family

- Interviews & assessments
- Invite dialogue about success and failure, share your stories
- Observe and individual's response to adversity
- Listen for language and use it in your conversations
  - Strengths
  - Sense of agency, hope, etc.

SAMPLE ASSESSMENTS

- Based upon a meta-analysis on resilience measures/assessments (Windle et al., 2011), 3 adult assessments were reviewed to have the strongest psychometric properties:

1. Connor-Davidson Resilience Scale (CD-RISC)
2. Resilience Scale for Adults (RSA)
3. Brief Resilience Scale (BRS)

NOTE: Other scales exist (including a number for children), but many scales were in early development and needed further research – for example, the Child and Youth Resilience Measure (CYRM) for at-risk youth is designed to be a culturally and contextually relevant measure. The manual is available online: http://www.resilienceresearch.org/files/CYRM/Child%20-%20CYRM%20Manual.pdf

CONNOR-DAVIDSON RESILIENCE SCALE (CD-RISC)

- Target population: adults
- Self-report
- Measures 5 dimensions, has 25 items
- Developed for clinical practice to measure stress and coping ability; sees resilience as a personal quality.
- There is a short version developed in 2007 normed on young adults (10 items).

RESILIENCE SCALE FOR ADULTS (RSA)

- Target population: adults (developed in Norway)
- Self-report
- Measures 5 dimensions, has 37 items
- Used to examine protective factors presumed to facilitate adaptation to adversity.
- A 2005 version with 33 items was normed on adults in 20's and 30's.
- There is a short version developed in 2007 normed on young adults (10 items).

BRIEF RESILIENCE SCALE

- Target population: adults
- Self-report
- Measures 1 dimension, has 6 items
- Developed to asses ability to bounce back or recover from stress.

BRIEF RESILIENCE SCALE

Brief Resilience Scale (BRS)

Please respond to each item by marking one box per row	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
I tend to bounce back quickly after hard times	1	2	3	4	5
I have a hard time making it through stressful events.	5	4	3	2	1
It does not take me long to recover from a stressful event.	1	2	3	4	5
It is hard for me to snap back when something bad happens.	5	4	3	2	1
I usually come through difficult times with little trouble.	1	2	3	4	5
I tend to take a long time to get over set-backs in my life.	5	4	3	2	1

Scoring: Add the responses varying from 1-5 for all six items giving a range from 6-30. Divide the total sum by the total number of questions answered.

My score: _____ (item average / 6)

SUICIDE RESILIENCE INVENTORY-25 (SRI-25)

- Studies supporting its use in adolescent psychiatric populations and in college students
- Factor analyses indicated support for the three dimensions it measures:
  - Internal Protective Scale
  - Emotional Stability
  - External Protective Scale

HOW WE MIGHT CULTIVATE RESILIENCE

- In ourselves
  - **Make connections with others.**
  - **Avoid seeing crises as insurmountable problems.**
  - **Accept that change is a part of living.**
  - **Move toward your goals. Take decisive actions.**
  - **Nurture a positive view of yourself.**
  - **Keep things in perspective.**
  - **Maintain a hopeful outlook.**
  - **Take care of yourself.**
  - **Reflect**

HOW WE MIGHT CULTIVATE RESILIENCE

- As Clinicians
- As Educators
- As Friends and Family members

- What are your ideas? Success stories?

RESOURCES ON RESILIENCE

- Edutopia resources:
  - http://www.edutopia.org/resilience-grit-resources
- Resilience Project
  - https://undergrad.stanford.edu/resilience
- The Princeton Perspective Project
  - https://perspective.princeton.edu/
- The Success-Failure Project
  - http://successfailureproject.bsc.harvard.edu/
- The Princeton Perspective Project
  - https://perspective.princeton.edu/
- The Mindset Kit
  - https://www.mindsetkit.org/about

ENDING THOUGHTS…

I have learned that success is to be measured not so much by the position that one has reached in life as by the obstacles overcome while trying to succeed.
- *Booker T Washington*

I am not what happened to me, I am what I choose to become.
- *Carl Gustav Jung*

I am not afraid of storms for I am *learning* how to *sail my ship*."
- *Louisa May Alcott*

QPR Gatekeeper Training

- Welcome
- Introduction

Information about Depression

- Up to 25% of all Americans experience an episode of clinical depression during their lifetimes.
- Majority of depressed young adults don't receive treatment.
- Untreated depression is **the #1 cause of suicide**.
- Depression is **treatable**.

Symptoms of Depression

- Changes in sleep patterns (either more or less)
- Changes in appetite (either more or less)
- Decrease in self-esteem
- Increase in social isolation
- Decrease in concentration
- Decrease in energy and motivation
- Increase in alcohol and other substances

Symptoms of Depression (cont.)

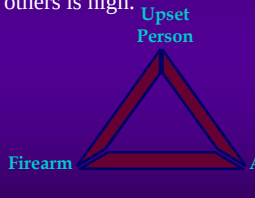
- Increase in irritability (especially in adolescents!)
- Increase in worrying and brooding
- Increase in tearfulness
- Less enjoyment of previously pleasurable activities
- Hopelessness; pessimistic outlook
- Thoughts of death, suicide, or self harm

Mental Illness and Suicide

- About 90% of all people who die by suicide are suffering from a major psychiatric illness:
  - Depression
  - Addiction
  - Anxiety
- These deaths are most often due to untreated or under-treated brain disorders.

The Deadly Triad

When these three are present, the risk of violence to self or others is high.



If you eliminate or resolve any side of the triangle, the immediate risk of violence to self or others is reduced!

Triggers or Last Straws

Loss of an idealized or important relationship
The "unacceptable wound"
Sudden sobriety and painful reality
Drug or alcohol relapse
Threat of loss
Health issues or concerns

Triggers or Last Straws (cont.)

Discharge phenomenon
Fear of becoming a burden to others
Lifting of depression
Contagion effect
Anything that "winks out the last ray of hope"

Increasing Hopelessness

- Hopelessness is the "final common pathway"
- The association between suicidality and hopelessness is stronger and more stable than the association of suicidality with depression and substance use disorders.

Epidemiology

- 3.7 male deaths by suicide for each female death.
- Populations at greatest risk
  - white males (especially elderly and those ages 40-59)
  - Native American (ages 10-39)
  - LGBT Youth
  - Veterans – 2 times as likely to die by suicide than not veterans

Considerations Regarding Methods/Means

- Suicide attempts by guns are **nearly always fatal** (versus 5% of the time by cutting and 23% by overdosing).
- To complete suicide by **hanging,** one does not have to be suspended.
- To complete suicide by **jumping,** one does not have to jump out of a multiple story building.

QPR Gatekeeper Training

- Suicide is Preventable!!

QPR

Ask A Question, Save A Life

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Question, Persuade, Refer

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- QPR is <u>not</u> intended to be a form of counseling or treatment.
- QPR <u>is</u> intended to offer hope through positive action.

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Suicide Myths and Facts

- **Myth** No one can stop a suicide, it is inevitable.
- **Fact** If people in a crisis get the help they need, they will probably never be suicidal again.
- **Myth** Confronting a person about suicide will only make them angry and increase the risk of suicide.
- **Fact** Asking someone directly about suicidal intent lowers anxiety, opens up communication and lowers the risk of an impulsive act.
- **Myth** Only experts can prevent suicide.
- **Fact** Suicide prevention is everybody's business, and anyone can help prevent the tragedy of suicide

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Myths And Facts About Suicide

- **Myth** Suicidal people keep their plans to themselves.
- **Fact** Most suicidal people communicate their intent sometime during the week preceding their attempt.
- **Myth** Those who talk about suicide don't do it.
- **Fact** People who talk about suicide may try, or even complete, an act of self-destruction.
- **Myth** Once a person decides to complete suicide, there is nothing anyone can do to stop them.
- **Fact** Suicide is the most preventable kind of death, and almost any positive action may save a life.

How can I help? Ask the Question...

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Suicide Clues And Warning Signs

The more clues and signs observed, the greater the risk. Take all signs <u>seriously.</u>

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Direct Verbal Clues:

- "I've decided to kill myself."
- "I wish I were dead."
- "I'm going to commit suicide."
- "I'm going to end it all."
- "If (such and such) doesn't happen, I'll kill myself."

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- "I'm tired of life, I just can't go on."
- "My family would be better off without me."
- "Who cares if I'm dead anyway."
- "I just want out."
- "I won't be around much longer."
- "Pretty soon you won't have to worry about me."

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Behavioral Clues:

- Any previous suicide attempt
- Acquiring a gun or stockpiling pills
- Co-occurring depression, moodiness, hopelessness
- Putting personal affairs in order
- Giving away prized possessions
- Sudden interest or disinterest in religion
- Drug or alcohol abuse, or relapse after a period of recovery
- Unexplained anger, aggression and irritability

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Situational Clues:

- Being fired or being expelled from school
- A recent unwanted move
- Loss of any major relationship
- Death of a spouse, child, or best friend, especially if by suicide
- Diagnosis of a serious or terminal illness
- Sudden unexpected loss of freedom/fear of punishment
- Anticipated loss of financial security
- Loss of a cherished therapist, counselor or teacher
- Fear of becoming a burden to others

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Tips for Asking the Suicide Question

- If in doubt, don't wait, ask the question
- If the person is reluctant, be persistent
- Talk to the person alone in a private setting
- Allow the person to talk freely
- Give yourself plenty of time
- Have your resources handy; QPR Card, phone numbers, counselor's name and any other information that might help

Remember: How you ask the question is less important than that you ask it

Q QUESTION

Less Direct Approach:

- "Have you been unhappy lately?
  Have you been very unhappy lately?
  Have you been so very unhappy lately that you've been thinking about ending your life?"

- "Do you ever wish you could go to sleep and never wake up?"

Q QUESTION

Direct Approach:

- "You know, when people are as upset as you seem to be, they sometimes wish they were dead. I'm wondering if you're feeling that way, too?"
- "You look pretty miserable, I wonder if you're thinking about suicide?"
- "Are you thinking about killing yourself?"

NOTE: If you cannot ask the question, find someone who can.

How Not to Ask the Question

"You're not suicidal, are you?"

P PERSUADE

HOW TO PERSUADE SOMEONE TO STAY ALIVE

- Listen to the problem and give them your full attention
- Remember, suicide is not the problem, only the solution to a perceived insoluble problem
- Do not rush to judgment
- Offer hope in any form

P PERSUADE

Then Ask:

- Will you go with me to get help?"
- "Will you let me help you get help?"
- "Will you promise me not to kill yourself until we've found some help?"

YOUR WILLINGNESS TO LISTEN AND TO HELP CAN REKINDLE HOPE, AND MAKE ALL THE DIFFERENCE.

R REFER

- Suicidal people often believe they cannot be helped, so you may have to do more.
- The best referral involves taking the person directly to someone who can help.
- The next best referral is getting a commitment from them to accept help, then making the arrangements to get that help.
- The third best referral is to give referral information and try to get a good faith commitment not to complete or attempt suicide. Any willingness to accept help at some time, even if in the future, is a good outcome.

REMEMBER

Since almost all efforts to persuade someone to live instead of attempt suicide will be met with agreement and relief, don't hesitate to get involved or take the lead.

For Effective QPR

- Say: "I want you to live," or "I'm on your side...we'll get through this."
- Get Others Involved. Ask the person who else might help. Family? Friends? Brothers? Sisters? Pastors? Priest? Rabbi? Bishop? Physician?

For Effective QPR

- Join a Team. Offer to work with clergy, therapists, psychiatrists or whomever is going to provide the counseling or treatment.
- Follow up with a visit, a phone call or a card, and in whatever way feels comfortable to you, let the person know you care about what happens to them. Caring may save a life.

REMEMBER

WHEN YOU APPLY QPR, YOU PLANT THE SEEDS OF HOPE. HOPE HELPS PREVENT SUICIDE.